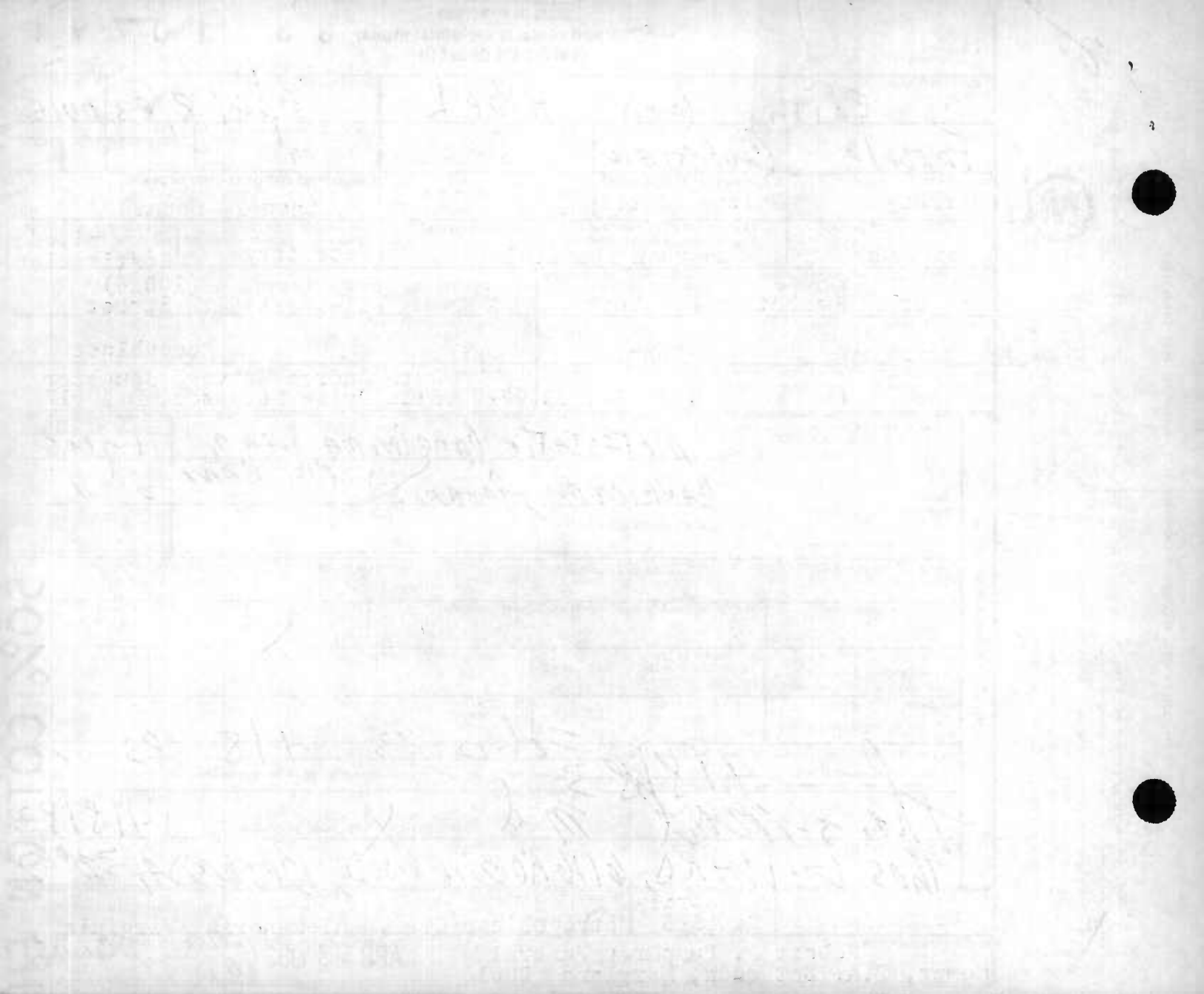


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 83 10791							
1. DECEASED NAME (TYPE OR PRINT)		Edith (nm)		LAST ABEL		2a. DATE OF DEATH MONTH DAY YEAR		April 8, 83 0415M	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY United Restitution	
13a. STATE New York		13b. COUNTY Manhattan		13c. CITY OR TOWN New York		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS (10024) 316 West 84th Street	
14. FATHER'S NAME FIRST MIDDLE LAST Bernhard Cohn		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lina Rosenblatt		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)					
16b. SOCIAL SECURITY NO. 131-14-4363		17. INFORMANT Ruth Andrea Harvey, daughter ADDRESS 9210 Villa Drive Bethesda, MD 20817							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 1629 METASTATIC CARCINOMA LUNG, LIVER, BONE								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17EN	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) CARCINOMA, PANCREAS								2 11	
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/8/83 to 4/8/83, that (I) (we) last saw the deceased alive on 4/8/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE Thos L. Ward M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/8/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thos L. Ward, 6116 Robinwood, Bethesda, MD 20817		22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April 9, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814		25a. DATE REC'D. BY REGISTRAR APR 13 1983		25b. REGISTRAR'S SIGNATURE John J. Conner					





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 7 9 2

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SR. M. FLORENCE LUCILE AIDT C.S.C.			2a. DATE OF DEATH MONTH DAY YEAR 4 8 83		2b. HOUR 5 25 AM
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR 8 29 1896		6. AGE IN YEARS (LAST BIRTHDAY) 86	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH KENSINGTON	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SAINT ANGELO HALL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Catholic Nun		12b. KIND OF BUSINESS OR INDUSTRY RELIGION
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN Maryland Montgomery Kensington		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS 1500 STRATHMORE AVENUE 20895	
14. FATHER'S NAME FIRST MIDDLE LAST GUSTAVE F AIDT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LUCKY - MURPHY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES No		16b. SOCIAL SECURITY NO. 579-66-5480		17. INFORMANT Sister Maureen Patrice ADDRESS Same as 13	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4360

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost

(b) ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/2 1982 to 4/8 1983, and that (I) (we) lost the deceased on 4/2 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) did not view the body after death.					
22b. SIGNATURE Mark H. 216, M.D.		DEGREE		22c. DATE SIGNED 4/8/83	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)		23b. ADDRESS			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Apr. 12, 1983	23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D. C.
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24. FUNERAL DIRECTOR NAME Francis J. Collins 500 University Boulevard, W. Silver Spring, Md.	25a. DATE REC'D. BY REGISTRAR APR 12 1983	25b. REGISTRAR'S SIGNATURE John J. Connel
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

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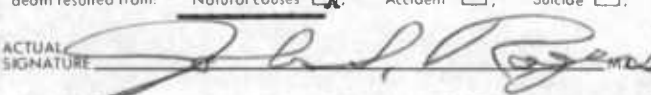
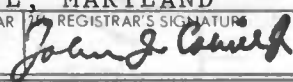
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72

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE NEAREST DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 10793	
1- FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) <b>Mildred Bernice Aldrich</b>								2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>4/3</b> DAY <b>19</b> YEAR <b>83</b>		2b. HOUR <b>7:00</b> M <b>P.</b>			
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>Feb.</b> DAY <b>15</b> YEAR <b>1911</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>72</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD <b>4/3</b> MONTH DAY YEAR <b>19 83</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash., D. C.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8830 Piney Branch Road, #405</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Fed. Gov.-Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8830 Piney Branch Road, #405</b>			
14. FATHER'S NAME FIRST <b>Leroy</b> MIDDLE <b>Harkins</b> LAST						15. MOTHER'S MAIDEN NAME FIRST <b>Rosa</b> MIDDLE <b>Hawkins</b> LAST							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>579-10-0250</b>		17. INFORMANT <b>Elaine Scott</b> ADDRESS <b>5255 Runningbrook Rd. Columbia, Md. 21044</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b> <b>4291</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>													
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE 				TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER						DATE SIGNED <b>4/4/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>4/7/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MARYLAND NATIONAL</b>				23d. LOCATION CITY OR TOWN <b>LAUREL, MARYLAND</b> COUNTY STATE			
24. FUNERAL DIRECTOR <b>MORROW &amp; WOODFORD, INC.</b>				25. DATE REC'D. BY REGISTRAR <b>APR 8 1983</b>				25. REGISTRAR'S SIGNATURE 					

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

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None

None

John A. Brown, N.D.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1 AND 2 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10794	
1. FOR STATE REGISTRAR										2a. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elmo Bowie Allen, Jr.										2b. HOUR 4 27 19 83	
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR OCT 28 1940 42 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) 42 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 4 27 19 83	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Gaithersburg				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE md										13b. CITY OR TOWN Frederick	
14. FATHER'S NAME FIRST MIDDLE LAST ELMO ALLEN										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thehma Bowie ALLEN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 212-38-9921	
17. INFORMANT ADDRESS Mrs. Judy ALLEN 214 Washington ST										18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	
PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										(b) DUE TO, OR AS A CONSEQUENCE OF	
(c) DUE TO, OR AS A CONSEQUENCE OF											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth M.D.				TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 4-27-83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-30-1983				23c. NAME OF CEMETERY OR CREMATORY Elenezer			
24. FUNERAL DIRECTOR NAME C. E. Hicks				ADDRESS 2632 W. PATRICK ST.				25a. DATE REC'D. BY REGISTRAR MAY 5 1983			
								25b. REGISTRAR'S SIGNATURE John J. Canine			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (1))  
15M/2/80

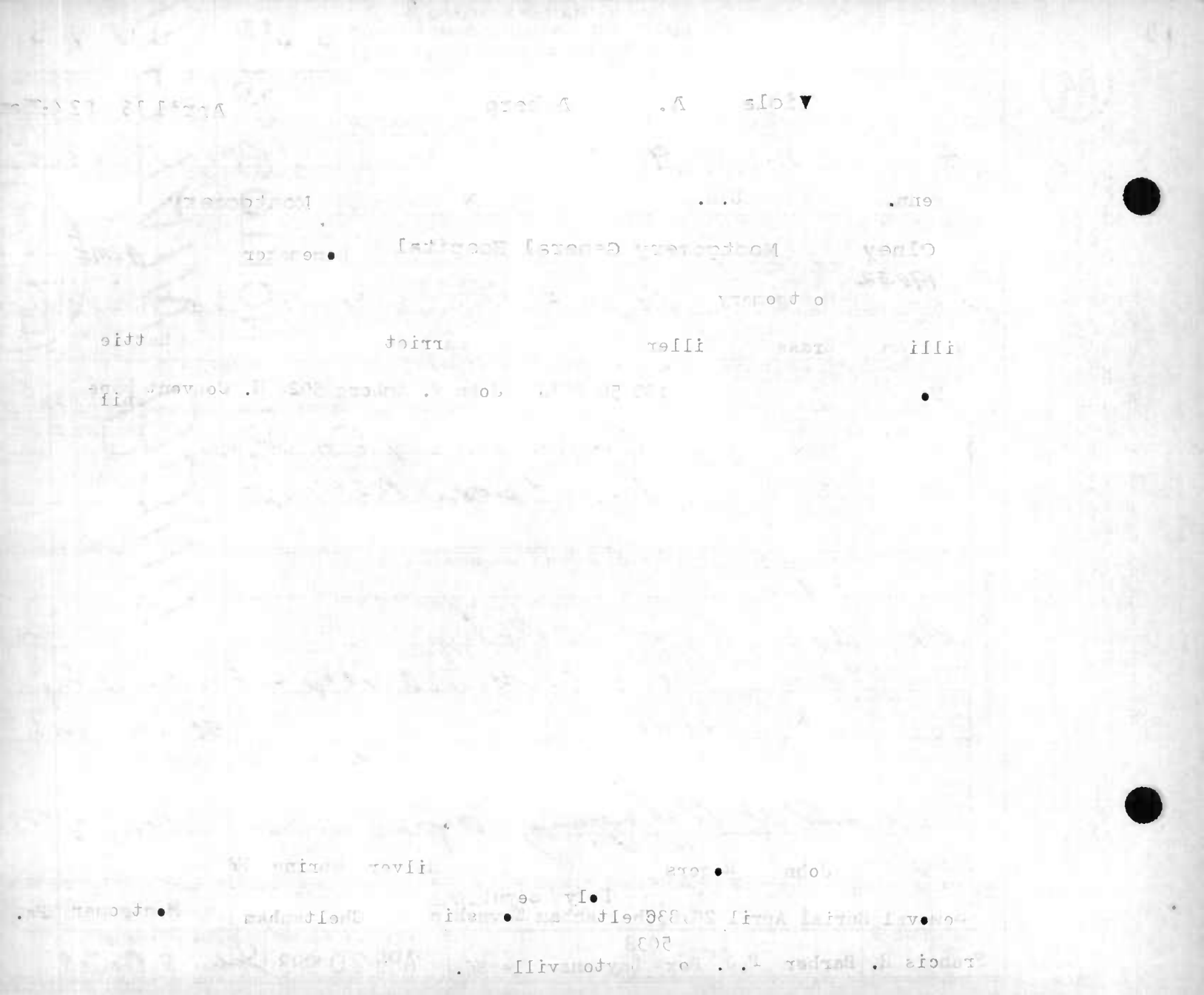
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Viola A. Amberg</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>April 16 1983 4:35 AM</b>		
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 9 1909</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>89 YRS</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penn.</b>		7c. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	
13a. STATE <b>Penn.</b>		13b. CITY OR TOWN <b>Montgomery</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Grass Miller</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Harriet Battie</b>		17. INFORMANT ADDRESS <b>John W. Amberg 5024 N. Convent Lane Phil., Pa</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>162 50 9076</b>		17. INFORMANT ADDRESS <b>John W. Amberg 5024 N. Convent Lane Phil., Pa</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>8809 Pulmonary Embolus</b> IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: <b>Fracture Rt Hip</b> (b) <b>Fracture Rt Hip</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>					
19a. DATE OF OPERATION <b>April 4 83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>Fracture Rt hip</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4:30 P.M. 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Mixed step &amp; Fractured hip</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Mont. Md</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <b>John Rogers</b>		TITLE (SPECIFY) <b>M.D. Dep</b>		MEDICAL EXAMINER <b>John W. Amberg</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>John Rogers</b>		ADDRESS <b>Silver Spring Md</b>		DATE <b>April 16, 1983</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal Burial</b>		23b. DATE <b>April 20, 1983</b>		23c. NAME OF METEOROLOGICAL SERVICE <b>Cheltenham Township</b>	
24. FUNERAL DIRECTOR NAME <b>Francis H. Barber</b>		ADDRESS <b>P.O. Box Laytonsville Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 20 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John W. Amberg</b>		25c. REGISTRAR'S SIGNATURE <b>John W. Amberg</b>			

999999



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>ETHA M Anderson</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>4-4-83</b>				2b. HOUR <b>4:30 A</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>3-26-13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Indiana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>49 Stonegate Drive 20904</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ernest Wever</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Crawford</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Judith Li-daughter-(same as 13e)</b>				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardiovascular collapse due to</b> <b>2500</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>severe coronary artery disease -</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>diabetes mellitus - renal insufficiency</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/10</b> , 19 <b>83</b> , to <b>4/4</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>4/3/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Joseph M. Solinas for Dr. Keenauer</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>4/4/83</b>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph M. Solinas, MD</b>				22f. ADDRESS <b>9801 Ga. Avenue, Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4-8-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Erie Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bedford Lawrence Indiana</b>			
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>				11800 N.H. Ave., <b>Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	



*[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "Haver" and "Wax" are visible.]*

*[Faint text at the bottom of the page, including what appears to be a date "1901" and a name "Joseph A. Sullivan".]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 1 0 7 9 7	
1. FOR STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ERVING E. ANDERSON			2a. DATE OF DEATH MONTH DAY YEAR APRIL 25 83		2b. HOUR 2:05 P.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR SEPT 15, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CONNECTICUT		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH OLNEY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BROOKE GROVE NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ELECTRICAL TECH		12b. KIND OF BUSINESS OR INDUSTRY NOL
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN KENINGTON	
14. FATHER'S NAME FIRST MIDDLE LAST CHARLES A. ANDERSON			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SELMA PETERSON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 040-09-5352		17. INFORMANT ADDRESS RUTH E. DOWNS SAME AS 13 DAUGHTER	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 TERMINAL PULM. CONGESTION DUE TO, OR AS A CONSEQUENCE OF (b) CEREBRAL ISCHEMIC EPISODE 3 DAYS DUE TO, OR AS A CONSEQUENCE OF (c) CEREBRAL ARTERIOSCLEROSIS YES. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. SENILE DEMENTIA - SEVERE						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 5/21		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 81 4/25 83		
22a. I certify that (I) (this hospital) attended the deceased from 5/21 1981 to 4/25 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes listed above (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE OF PHYSICIAN Donald R. Lewis MD		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 4/25/83
22f. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD R. LEWIS MD		22g. ADDRESS OLNEY MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/28/83		23c. NAME OF CEMETERY OR CREMATORY FT. LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS				25a. DATE REC'D. BY REGISTRAR APR 28 1983		25b. REGISTRAR'S SIGNATURE John J. Conner
500 INTV. BLVD. W. SILVER SPRING, MD. 20901						

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN DIVISION 773 STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

**(M)**

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										8 3 10798 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <i>Nell Horton Anderson</i>							2a. DATE KNOWN OF DEATH ESTIMATED <i>April 19, 83</i>		MONTH DAY YEAR		
1. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>5 10 08</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>74 YRS.</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <i>April 18, 1983</i>		MONTH DAY YEAR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD					
10. CITY OR TOWN OF DEATH <i>Tak Park</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wash. Advent. Hosp</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Secretary</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Insurance</i>			
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <i>Md.</i>		13b. COUNTY <i>Mont.</i>		13c. CITY OR TOWN <i>Tak Park</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>7087 Carroll Ave</i>		20912	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Sidney S. Horton</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rebecca</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>No</i>			16b. SOCIAL SECURITY NO. <i>578-14-9411</i>		17. INFORMANT <i>Mr. David Anderson</i>		ADDRESS <i>P.O. Box 84 Bryans Road, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <i>8880 Pulmonary Embolus</i> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <i>Fracture Rt hip</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>											
19a. DATE OF OPERATION <i>4/16/83</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fracture Rt hip</i>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>4-8 1983</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>Fell at home</i>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Home</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>Carroll Ave Tak Park Mont Md</i>						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) <i>M.D. Dep.</i>			MEDICAL EXAMINER			DATE SIGNED <i>April 11, 1983</i>		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS								
22b. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>			22c. DATE <i>4/20/83</i>		22d. NAME OF CEMETERY OR CREMATORY			22e. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Anatomy Board Balto., Md.</i>					23a. DATE REC'D. BY REGISTRAR <i>APR 25 1983</i>		23b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>				

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RECEIVED

NOV 20 1964



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10799

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Anne E. Argerie</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>April 28, 1983</i>		2b. HOUR <i>8:17 P</i>
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH <i>MARCH 1, 1916</i>	6. AGE (IN YEARS LAST BIRTHDAY) <i>67</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Bd. of Education</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Montgomery Cty</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Wheaton</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Jack Dambrosio</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Jennie Litterilli</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>579-03-6406</i>		17. INFORMANT ADDRESS <i>Carl J. Argerie Husband Same as 13</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Bronchiectatic Lung Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>4940</i>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>4-28 1983</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>329</i>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>4-28 83</i>
22a. I certify that (I) (this hospital) attended the deceased from <i>4-28 1983</i> to <i>4-28 1983</i> , that (I) (we) last saw the deceased alive on <i>4-28 1983</i> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <i>Carol Mahoney</i>		22c. ADDRESS <i>SILVER SPRING, MARYLAND</i>		22d. DATE SIGNED <i>4/29/83</i>
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CAROL MAHONEY</i>		22f. ADDRESS <i>SILVER SPRING, MARYLAND</i>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>May 2, 1983</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring Mont. Md.</i>	23e. DATE REC'D. BY REGISTRAR <i>MAY 6 1983</i>
24. FUNERAL DIRECTOR <i>Francis J. Collins</i>		25. REGISTRAR'S SIGNATURE <i>John J. Connel</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ATKINS HOSPITAL



May 6 1958



Wine

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND										REG. NO.	
DEPARTMENT OF HEALTH AND MENTAL HYGIENE										10800	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		2b. HOUR
Allan Ray Ashley									DATE ESTIMATED		M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS	
MALE		WHITE		12-7-08		74 YRS.		MONTHS		DAYS	
								HOURS		MIN.	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
KENTUCKY			TACOMA PARK			WASHINGTON ADVENTIST			RET. POLICEMAN		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
MD			MONTG.			SILVER SPRING			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
WILLIAM			MARY			UNK.			557-07-0898		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
ZACHARY			PART I DEATH WAS CAUSED BY:			20. AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
(SAME AS #13)			IMMEDIATE CAUSE (a) Cardiac Shock								
			Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								
			(b) Acute Myocardial Infarction								
			DUE TO, OR AS A CONSEQUENCE OF								
			(c) Coronary Artery Disease								
			DUE TO, OR AS A CONSEQUENCE OF								
			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
			HOUR A.M. MONTH DAY YEAR								
			P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION					
						STREET					
						CITY OR TOWN					
						COUNTY					
						STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from:										22b. Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion	
Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE										TITLE (SPECIFY)	
FRANK GRAVINO										M.D.	
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS	
FRANK GRAVINO										5632 SHIELDS DR. BETH. Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION		
CREMATION			5-2-1983			CEDAR HILL CREM			SUITZLAND PG.C. Md.		
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
W.W. CHAMBERS CO. INC			MAY 3 1983			John J. Chambers					
NAME			ADDRESS								
W.W. CHAMBERS CO. INC			SILVER SPR.								

STATE OF NEW YORK





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR Gladys M. Atherholt					8 3 1 0 8 0 1 REG. NO.				
1 DECEASED NAME FIRST MIDDLE LAST GLADYS M ATHERHOLT					2a. DATE OF DEATH MONTH DAY YEAR APRIL 13 1983			2b. HOUR 11:25A.M.	
SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 09 14 92		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Miss.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. STATE Md. 20817		13b. COUNTY Mont.		13c. CITY OR TOWN Beth.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7408 Nevis Rd. 20817	
14. FATHER'S NAME FIRST MIDDLE LAST John P. Tingle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Keller					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 200-36-1813		17. INFORMANT ADDRESS Marianne Dawson Same As item # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) <u>Cerebral &amp; Deep Focal Lesions</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Cerebral Vascular Accident</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arterio Sclerosis &amp; Atherosclerosis</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u> <u>5-6 yrs.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <u>hospital</u> attended the deceased from <u>3/1/83</u> to <u>4/1/83</u> , that (I) <u>last</u> saw the deceased alive on <u>3/1/83</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did) <u>not</u> view the body after death.									
22b. SIGNATURE <u>Donald Q. Ekman</u>				DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/13/83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald Q. Ekman, M.D.				22e. ADDRESS 4720 Chevy Chase Dr. Chevy Chase, Md. 20815					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 4/14/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Md.		
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisc. Ave. N.W. Wash., D.C.</u>						25a. DATE REC'D. BY REGISTRAR <u>APR 21 1983</u> REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 10802			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>RALPH DOUGLAS BARLEN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 29 83</b>			
3. SEX <b>MALE</b>				2b. HOUR <b>1140 a.m.</b>			
4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 30 1920</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>62</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>COLORADO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED Military</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>USN</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN <b>MARYLAND PRINCE GEORGE HYATTSVILLE</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>DOUGLAS FREDERICK BARLEN</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARY O'FALLON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1940-1961 524-03-7720</b>		17. INFORMANT ADDRESS <b>MARION E. BARLEN 5923 15th AVE HYATTSVILLE MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA</b> <b>4960</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>COPD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 26</b> , 19 <b>83</b> , to <b>APRIL 29</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>APRIL 29</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD M. LYNCH</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>30 APRIL 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDWARD M. LYNCH</b>				22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/4/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>				25. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b> 26. REGISTRAR'S SIGNATURE <i>John J. Gough</i>			

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Washington National Insurance Co.      Washington National Insurance Co.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 0 3

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>William Glen Barnett</b>			2a. DATE OF DEATH MONTH <b>4</b> DAY <b>28</b> YEAR <b>83</b>			2b. HOUR <b>12:30</b> a. M	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>19</b> YEAR <b>1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b>	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>12630 Viers Mill Road Apt. 102</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Lubrication man</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>car dealer</b>							
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>12630 Viers Mill Rd. #102</b>		20853					
14. FATHER'S NAME FIRST <b>Guy</b> MIDDLE <b>S.</b> LAST <b>Barnett</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Elsie</b> MIDDLE <b>Maud</b> LAST <b>Wetzel</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>234 12 7391</b>		17. INFORMANT ADDRESS <b>Ruth Barnett same as 13e</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **acute respiratory failure**  
DUE TO, OR AS A CONSEQUENCE OF  
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.  
(b) **Chronic obstructive Pulmonary Disease**  
DUE TO, OR AS A CONSEQUENCE OF  
(c) **Brachyogenic carcinoma**

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

**Coronary heart failure**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (if it is hospital) attended the deceased from <b>11-15</b> 19 <b>83</b> , to <b>7-27</b> 19 <b>83</b> , that (if we) last saw the deceased alive above (if yes (did) and how) saw the body after death.							
22b. SIGNATURE <b>Dr. John Kijak, Jr.</b>				DEGREE <b>K</b>		22c. DATE SIGNED <b>4-28-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. John Kijak, Jr.</b>				22e. ADDRESS <b>344 University Blvd. W. Silver Spring, Md.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY <b>Pleasant View Memory Gardens</b>		23d. LOCATION (CITY OR TOWN) <b>Berkeley County, W. Va.</b>	
24. FUNERAL DIRECTOR NAME <b>Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Maryland 20852</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 29 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the Registrar of the Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be contacted for information.

MEDICAL CERTIFICATION

John D. Smith

899 B 5 88A



DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>BABY BOY BARRON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 26 '83</b>		2b. HOUR <b>2200 M</b>
3. SEX <b>MALE</b>	4. RACE <b>NEGRO</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>4 26 83</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>1 day</b>	IF UNDER 1 YEAR MONTHS DAYS <b>8 30</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NIA</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NIA</b>
13a. STATE <b>NIA MD</b>			13b. COUNTY <b>Prince George's</b>	13c. CITY OR TOWN <b>Seabrook</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <b>Gregor Kenneth Logan</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>WANDA m BARRON</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT ADDRESS <b>Wanda Barron 5147 N 13 E</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY ARREST</b> <b>7650</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Immaturity - 23 week gestation</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <b>NIA</b>					
19a. DATE OF OPERATION <b>NIA</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/26</b> , 19 <b>83</b> , to <b>4/26</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>4/26</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Arno L. Zaritsky MD</b>		DEGREE		22c. DATE SIGNED <b>4/26/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARNO L. ZARITSKY MD</b>		22e. ADDRESS <b>11913 Green Tee Turn, Upper Marlboro, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>4-30-83</b>		23b. DATE <b>4-30-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Greenbelt P.G. MD</b>		23e. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b>			
24. FUNERAL DIRECTOR NAME <b>H.S. Washington &amp; Sons</b>		ADDRESS <b>4435 Beauregard Ave NE</b>		25. REGISTRAR'S SIGNATURE <b>John G. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page # may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH-17  
(VR A15 ME (1))  
15M 2/80

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 10805							
1. DECEASED NAME (TYPE OR PRINT) <b>Harriet I. Botsford</b>				2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY 4 YEAR 29 83				2b. HOUR 6:30 A.M.							
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH 1 DAY 3 YEAR 26		6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH 4 DAY 29 YEAR 83		7d. HOUR 6:30 A.M.			
7a. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Rockville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION <b>5612 Pier Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Editor</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Electronics</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5612 Pier Drive 20851</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>Walter Marsh</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Isabelle Floyd</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>015 20 2034</b>				17. INFORMANT <b>Harry Botsford same as 13e</b>				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4960 IMMEDIATE CAUSE (a) Cardio Respiratory arrest.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Chronic obstructive</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>pulmonary Disease</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE <b>[Signature]</b>				TITLE (SPECIFY) M.D.				MEDICAL EXAMINER				DATE SIGNED <b>4-29-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John Leuber</b>				ADDRESS <b>8218 W. Sconsin Ave.</b>											
23a. BURIAL, CREMATION, REMOVAL (SP. CH.) <b>Cremation</b>				23b. DATE <b>5/2/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>				23d. LOCATION CITY OR TOWN <b>Alexandria, Virginia</b> STATE					
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Maryland 20852</b>								25a. DATE REC'D. BY REGISTRAR <b>MAY 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, pages 3 and 4 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 8 0 6	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>GEORGE L. BEACH</b>			2a. DATE OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>83</b> 2b. HOUR <b>10:36 P.M.</b>		
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH <b>JAN</b> DAY <b>1</b> YEAR <b>1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D. C.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONT</b> MD.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MILKMAN</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>PRINCE GEORGES BELTSVILLE</b>	13c. CITY OR TOWN <b>20705</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>GEORGE</b> MIDDLE <b>L.</b> LAST <b>BEACH</b>		15. MOTHER'S MAIDEN NAME FIRST <b>MARIE</b> MIDDLE <b>7.</b> LAST <b>HANSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>WW II 577-05-0332</b>		17. INFORMANT ADDRESS <b>DAUGHTER LINDA SANDERS 15 W. CHAPEL HILL DR NEWARK, DELAWARE 19711</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5715 IMMEDIATE CAUSE (a) Massive GI Hemorrhage</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Esophageal &amp; Small Bowel Varices</b>					<b>2 yrs</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cirrhosis, post-necrotic, &amp; Hepatoma</b>					<b>10 yrs</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4-8</b> , 19 <b>83</b> , to <b>4-8</b> , 19 <b>83</b> , that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>4-8</b> , 19 <b>83</b> , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE <b>G. Sengstack M.D.</b>				22c. DATE SIGNED <b>4-9-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE SENGSTACK</b>				22e. ADDRESS <b>SILVER SPRING, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4/12/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GEORGE WASHINGTON</b>	
23d. LOCATION <b>ADELPHI</b>		23e. PRI GEO		23f. MD. <b>ATE</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 14 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>					

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FRANCIS J. COLLINS

James G. Thompson



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										83	10807	
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH							REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
ELIZABETH LEONA BEALL						APRIL 5 1983			10 A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
FEMALE		CAUCASIAN		JUNE 2, 1899		83 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MARYLAND		U.S.A.				MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
SILVER SPRING		BEL PRE NURSING HOME				HOMEMAKER						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
MARYLAND		MONTGOMERY		SILVER SPRING				2621 BEL PRE ROAD 20906				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
JAMES THOMAS ATWOOD			PEARL HOUSER									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
NO			212-74-7454			SON EDMUND J. BEALL			2625 BEL PRE ROAD SILVER SPRING, MD. 20906			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 Cerebral Vascular Accident										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks.		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis										4 YRS		
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 4/4 1983 to 4/5 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE DEGREE						22c. DATE SIGNED						
R.T. BENACK MD						4/5/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS						
R.T. BENACK MD						4115 Colie DR. Wheaton MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL			4/8/83		GATE OF HEAVEN		SILVER SPRING MONT MD.					
24. FUNERAL DIRECTOR NAME						24b. ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
FRANCIS J. COLLINS						500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		APR 8 1983		John J. Smith		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified directly.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8310808

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GRADY BEASLEY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 11 1983</b>		2b. HOUR <b>1:00 P<sub>M</sub></b>
3. SEX <b>MALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 23 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>GEORGIA</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET ADDRESS <b>9301 CAROLINA AVENUE</b> 20901	
14. FATHER'S NAME FIRST MIDDLE LAST <b>MURPHY BEASLEY</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>VIOLA SHIELDS</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1942-1972</b>		17. INFORMANT ADDRESS <b>WILHELMENIA P. BEASLEY, 9301 CAROLINA AVENUE,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ADENOCARCINOMA OF COLON</b> <b>1539</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 8</b> , 19 <b>83</b> , to <b>APRIL 11</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>APRIL 11</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>R. K. FERGUSON, LT, MC, USNR</b>				22c. DATE SIGNED <b>12 APR 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. K. FERGUSON, LT, MC, USNR</b>				22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4-15-'83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	
23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>ARLINGTON, VIRGINIA</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Washington, DC Latney's Funeral Home 3831 Ga. Ave.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

MEDICAL CERTIFICATION

1940

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 0 9

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>LULA C. BEATTY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>04 07 83</b>		2b. HOUR <b>0558</b> A M	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB 10, 1926</b>		
6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF OCCUPATION OR WORKING LIFE) <b>HOMEMAKER</b>		
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS <b>RT 1, BOX 164B</b>		13b. CITY OR TOWN <b>21782</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM R. CALDWELL</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LULA B. de ATLEY</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>NO</b>		
16b. SOCIAL SECURITY NO. <b>578-26-4513</b>		17. INFORMANT NAME ADDRESS <b>JAY R. BEATTY SAME AS 13 HUSBAND</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hepatic Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Liver metastases</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Colon Cancer</b>		

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from <b>4/6</b> 19 <b>83</b> , to <b>4/6</b> 19 <b>83</b> , the (we) last saw the deceased alive on <b>4/6</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) saw the body after death.							
22b. SIGNATURE <b>Peter B. Sherer</b>				DEGREE <b>MD</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Peter Sherer</b>				22e. ADDRESS <b>3947 Ferrara St. Wheaton, Md 20906</b>		22f. PHYSICIAN'S NAME (TYPE OR PRINT)	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>4/8/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>		23d. LOCATION <b>ALEXANDRIA</b> COUNTY <b>VIRGINIA</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Gair</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon duplicate. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Handwritten signature: *John D. [illegible]*

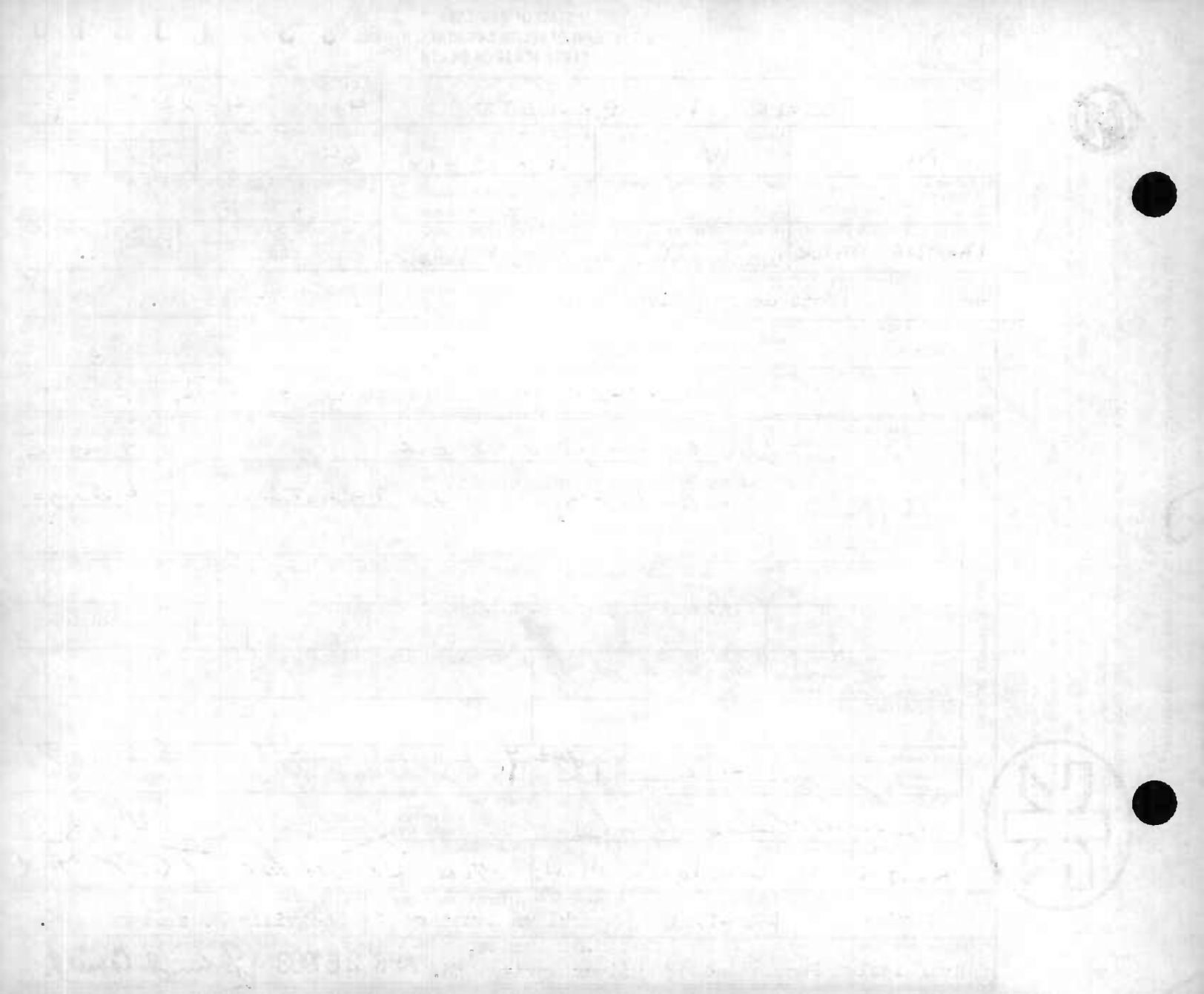
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Joseph P. BENNETT						2a. DATE OF DEATH MONTH DAY YEAR 4- 4-22-83		2b. HOUR 133 P M	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11-28-18		6. AGE (IN YEARS LAST BIRTHDAY) 64		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant		12b. KIND OF BUSINESS OR INDUSTRY US Govt.	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1100 Brantford Ave., 20904	
14. FATHER'S NAME FIRST MIDDLE LAST James Bennett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah (unknown)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (Gr-daughter) Debbie Papadopoulos		ADDRESS 6309 Riverdale Rd, Riverdale, Md. 20737			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiovascular Shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 6 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/17/83 to 4/22/83, that (I) (we) lost saw the deceased alive on 4/22/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Keith M. Lindgren M.D.				DEGREE		22c. DATE SIGNED 4/22/83		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Keith M. Lindgren, M.D.				22e. ADDRESS 7600 Carroll Ave TR. PK. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-26-1983		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				ADDRESS 11800 N.H. Avenue, Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR APR 26 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8310811			
1. DECEASED NAME (TYPE OR PRINT) Margaret M. Berry				2a. DATE OF DEATH 4/13/83				2b. HOUR 11:46 P.M.			
3. SEX Female		4. RACE W		5. DATE OF BIRTH 6 8 35		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 1 YEAR HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b. COUNTY Montg.		13c. CITY OR TOWN Silver Sp.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 313 Hobbyhorse Lane 20904			
14. FATHER'S NAME FIRST MIDDLE LAST Regis W. Buck				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret M. Newton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A				16b. SOCIAL SECURITY NO. (IF YES, GIVE NUMBER OR DATES) N/A		17. INFORMANT ADDRESS Charles J. Berry-husband- (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOPULMONARY ARREST</u> 7101 DUE TO, OR AS A CONSEQUENCE OF (b) <u>PULMONARY FIBROSIS</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>SCLERODERMA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 years 3 years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ( )											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1980</u> , to <u>April 13, 1983</u> , that (I) (we) last saw the deceased alive on <u>April 12, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.)											
22b. SIGNATURE <u>John J. Conner</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-13-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) TERENCE SCHNAPP, MD						22e. ADDRESS 11161 New Hampshire Ave Silver Spring MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4-16-1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home						11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 19 1983 John J. Conner			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 8 1 2			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Margaret E. Bevan				2a. DATE OF DEATH MONTH DAY YEAR April 26 83		2b. HOUR 9 A.M.	
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR Nov 11, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH KENSINGTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CIRCLE MANOR NURSING HOME		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION):				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13e. STREET ADDRESS 12609 EPPING ROAD 20906	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES W. KENDALL				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET E. GARRETT			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 212-03-6859		17. INFORMANT ADDRESS EVAN BEVAN SAME AS 13		HUSBAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 CARDIO-PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) ASHD - SEVERE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MINS YEARS.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: CHRONIC OBSTRUCTIVE PULMONARY DISEASE; DIABETES							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from SEPTEMBER 79, to APRIL 26, 1983, that (I) (we) lost saw the deceased alive on APRIL 12, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Harold W. Draper M.D.				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/26/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HAROLD W. DRAPER M.D.				22e. ADDRESS 9801 GEORGIA AVE, SILVER SPRING 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/29/83		23c. NAME OF CEMETERY OR CREMATORY PARKLAWN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE ROCKVILLE MONT MD.	
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE REC'D. BY REGISTRAR APR 28 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 8 1 3			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2b. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR			
John J. Bickings				April 19, 1983			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		MONTH DAY YEAR		62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Wash. D. C.		U. S. A.				Montgomery County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Silver Spring		Holy Cross Hospital		Mgr		Canada Dry Co.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		Montgomery		Wheaton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)			
John J. Bickings				Adele Virginia Ravelle			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT	
YES WW II				579-12-9842		Sharon E. Orcutt	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) 4100				immediate			
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
(b) acute myocardial infarction				1 day			
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 19, 1983, to April 19, 1983, that (I) (we) last saw the deceased alive on April 19, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
La. Paul Bickings				MO		Apr 20 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
La. Paul Bickings				1811 Pina Philip H. Dwyer, Md			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		4/23/83		Gate of Heaven Cemetery		Silver Spring, Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Warner E. Pumphrey, Inc.,				P.O. Box 7428		John J. Conner	
				APR 28 1983			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 3 10814	
1. DECEASED NAME (TYPE OR PRINT) <b>CHASE VINTON BICKLE JR.</b>						2a. DATE KNOWN OF DEATH <b>4 27 1983</b>		2b. HOUR <b>10 PM</b>			
3. SEX <b>M</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH <b>4 23 33</b>	6. AGE (IN YEARS) <b>50</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD <b>4 27 1983</b>		2d. HOUR <b>10 PM</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Texas</b>		7b. CITIZEN OF WHAT COUNTRY <b>USA</b>		8. <del>XXXXXX</del> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD</b>					
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Entertainer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>MD</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7541 SPRING LAKE DR 20887</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Chase V. Bickle</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lida Rutherford</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>Korean</b>		16b. SOCIAL SECURITY NO. <b>unobtainable</b>		17. INFORMANT ADDRESS <b>Gussie Bloxham-step-mother 302 N. Elen New Boston, TX 75570</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGIC SHOCK</b> DUE TO, OR AS A CONSEQUENCE OF 3030 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>HEPATO RENAL FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ALCOHOLISM</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1-2 MO YRS</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>—</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— — 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>COLLAPSED AT HOME</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>7541 Spring Lake Dr. Bethesda Mount. MD</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Francis C. Mayo</b>				TITLE (SPECIFY) <b>Sgt</b>		MEDICAL EXAMINER		DATE SIGNED <b>4/27/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C. Mayo</b>				ADDRESS <b>820 Wisconsin Ave Bethesda MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>4-28-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington DC</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi Funeral Home 11800 N.H. Ave., S.S. Md.20904</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Church</b>					

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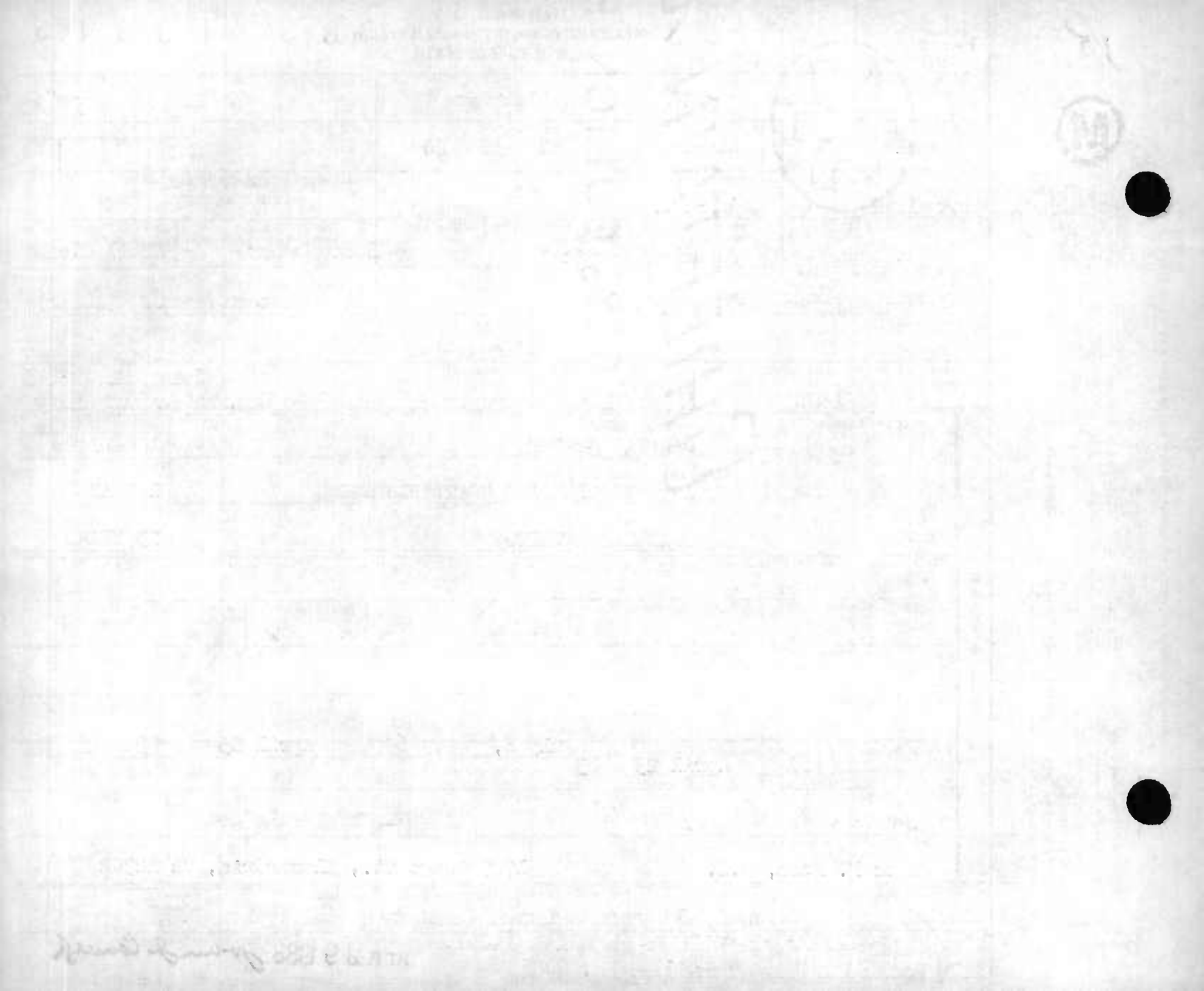
DHMH - 16 50M 1/81  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Papers retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 83 10815							
1. DECEASED NAME (TYPE OR PRINT) MILTON H. BLECHMAN					2a. DATE OF DEATH 4 25 83			2b. HOUR 5 <sup>00</sup> P M	
3. SEX Male		4. RACE Cauc.		5. DATE OF BIRTH MO 2 <sup>nd</sup> 15 <sup>th</sup> 14 <sup>th</sup> YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 69		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Store Owner		12b. KIND OF BUSINESS OR INDUSTRY Retail Clothing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland					13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Gus Blechman					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Gerber				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW11		17. INFORMANT ADDRESS Chase, Md. 20815 Eugenia Blechman; 6410 Western Avenue; Chevy Chase, Md. 20815					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ARTERIOSCLEROTIC HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DIABETES MELLITUS</u> Approximate interval between onset and death <u>2500</u> <u>1 YEAR</u> <u>23 YEARS</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>July 6,</u> 19 <u>69</u> , to <u>April 25</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>April 25</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>James M. Moss</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James M. Moss, M.D.				22e. ADDRESS 1707 Osage St., Alexandria, VA 22302					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/27/83		23c. NAME OF CEMETERY OR CREMATORY Adas Israel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR APR 29 1983					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 8 1 6			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
Mary		E.				Bloyd		April		8	83	4:15a	AM
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		Dec. 16, 1896		86 YRS		MONTHS		DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						MD.	
West Virginia		USA				Montgomery							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring, Md		Chevy Chase Retirement & N.H.		Homemaker		At Home							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md. 20910		Montgomery		Silver Spring		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2015 East		20910 West Highway			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST			
Henry		Ernest				Mary		Ann		Lawler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
No		234-24-3574		Thomas Riggs,		4005 Noyes Avenue		Charleston, W.Va.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Cardiac Arrest													
5860													
DUE TO, OR AS A CONSEQUENCE OF													
(b) Renal failure													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION									
				STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from June 1, 1978, to April 7, 1983, that (I) (we) lost saw the deceased alive on April 7, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE				ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN				22c. DATE SIGNED			
Christopher Unger, M.D.										4/8/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
		8218 Wisconsin Ave. Bethesda, Md. 20814											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE	
Burial		4/14/83		Mt. Rose Cemetery		Moundsville, West Virginia							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Joseph Gawler's Sons, Inc.		APR 13 1983				John J. Gawler							
NAME		ADDRESS											
5130 Wisconsin Ave., N.W., Washington, D.C. 20016													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 8 1 7	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Elizabeth C. Blum</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 20, 1983</b>			2b. HOUR <b>5 A M</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 17, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Potomac</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>7815 Coddle Harber Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Md. 20854</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Potomac</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>7815 Coddle Harber Lane</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>August Kramer</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma (Unknown)</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>102-28-1414</b>		16c. INFORMANT <b>Mrs. Sigrid McCutcheon</b>		ADDRESS <b>Potomac, Md. 11229 Falls River Ct.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4149 IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 HOUR</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b>										<b>1 YEAR</b>	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>ESSENTIAL HYPERTENSION</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 25</b> , 19 <b>73</b> , to <b>APRIL 20</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>MARCH 31</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <b>Edward A. Beeman</b>					DEGREE <b>M.D.</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>APRIL 20, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Dr. Edward A. Beeman</b>					22e. ADDRESS <b>8830 Cameron St. Sil. Spg. Md. 20910</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>			23b. DATE <b>4/21/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b> <b>5130 Wisc. Ave. N.W. Wash., D.C. 20016</b>					25a. DATE REC'D. BY REGISTRAR <b>APR 25 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John E. Smith</b>				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16-50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 8 1 8	
1- FOR STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MORRIS	MIDDLE	LAST BLUMBERG	2a. DATE OF DEATH MONTH DAY YEAR 4 5 83
3 SEX Male		4 RACE White	5. DATE OF BIRTH MONTH DAY YEAR MARCH 6, 1900		6 AGE (IN YEARS LAST BIRTHDAY) 83 YRS.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hebrew Home of Greater Washington		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner (Ret.)	12b. KIND OF BUSINESS OR INDUSTRY Retail Shoes
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Virginia		13c CITY OR TOWN McLean	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 905 Ridge Drive (22101)
14 FATHER'S NAME FIRST MIDDLE LAST Joseph Blumberg		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. 182-05-8039		17 INFORMANT ADDRESS Sylvia Kaplan; 905 Ridge Drive; McLean, Va. 22101	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a: <u>Atherosclerotic Cerebrovascular Disease</u>					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) <u>(this hospital)</u> attended the deceased from <u>February 1</u> , 19 <u>83</u> , to <u>April 5</u> , 19 <u>83</u> , that (1) <u>(we)</u> lost saw the deceased alive on <u>April 5</u> , 19 <u>83</u> , and that in (my <u>own</u> ) opinion death occurred on the date and hour and from the causes stated above, (1) <u>(we)</u> (did not) view the body after death.					
22b. SIGNATURE <u>Barry Hecht</u>		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY HECHT		22e ADDRESS 3929 FERRARA DRIVE WHEATON, MD 20906			
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 4/8/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Sharon Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Springfield, Pennsylvania		24 FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS ADDRESS 1170 Rockville Pike; Rockville, Maryland 20852			
25a. DATE REC'D. BY REGISTRAR APR 11 1983				25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

APR 11 1964

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COLLON 11111



APR 11 1964

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Kathleen Rose Bohlen</i>			2a. DATE KNOWN OF DEATH ESTIMATED <i>April 4, 1983</i>			2b. HOUR <i>6:20</i>		
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>Jan 30 20 63</i>	6. AGE (IN YEARS LAST BIRTHDAY) YEARS <i>20</i>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD <i>April 4, 1983</i>	2d. HOUR <i>8:30</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Iowa</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i>		
10. CITY OR TOWN OF DEATH <i>Sil. Spr</i>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>14432 Taos Ct</i>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Home maker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>	
13a. STATE <i>MD</i>		13b. COUNTY <i>Mont.</i>	13c. CITY OR TOWN <i>Sil. Spr</i>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <i>14432 Taos Ct</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Frank Kuhlenbeck</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Della Rose (unknown)</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>482-16-7636</i>		17. INFORMANT ADDRESS <i>14432 Taos Court</i> <i>Toni V. Gordon Sil. Spr., MD 20906</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> <i>4291</i> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>								
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) M.D. <i>Dep.</i>		MEDICAL EXAMINER		DATE SIGNED <i>April 5/83</i>		
EXAMINER'S NAME (TYPE OR PRINT) <i>Dr. John S. Rogers, DME</i>		ADDRESS <i>1919 Seminary Rd. Sil. Spr., MD</i>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/7/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat'l Cem. Arlington</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>VA</i>		
24. FUNERAL DIRECTOR NAME <i>Warner E. Pumphrey, Inc.</i>		ADDRESS <i>P.O. Box 7428</i>		25a. DATE REC'D BY REGISTRAR <i>APR 8 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John S. Rogers</i>		

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Handwritten signature or mark.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 2 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GRACE M Booth			2a. DATE OF DEATH MONTH DAY YEAR 4 8 83		2b. HOUR 10 PM						
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 31 1943		6. AGE (IN YEARS LAST BIRTHDAY) 39 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse			12b. KIND OF BUSINESS OR INDUSTRY Nursing		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland		13c. COUNTY Montgomery		13d. CITY OR TOWN Rockville		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 4625 Cherry Valley Dr. 20853			
14. FATHER'S NAME FIRST MIDDLE LAST Vincent Policelli				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosalee Gentilcore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT Jerry Booth - husband- (same as 13e)		ADDRESS 20853					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock Lung - Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) Gram Negative Septicemia DUE TO, OR AS A CONSEQUENCE OF (c) Non Hodgkin Lymphoma Bone Marrow 2028										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 2 days 3 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Cold Agglutination Disease - Hemolytic Anemia											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 19 80, to 7 April 19 83, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eugene P. Libre MD						DEGREE MD			22c. DATE SIGNED 9 April 83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. LIBRE						22e. ADDRESS 10400 Greenleaf Rd Pineyville Md. 20855					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-12-1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven			23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Montgomery Md.			
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md.						25a. DATE REC'D. BY REGISTRAR APR 11 1983			25b. REGISTRAR'S SIGNATURE John J. Canfield		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

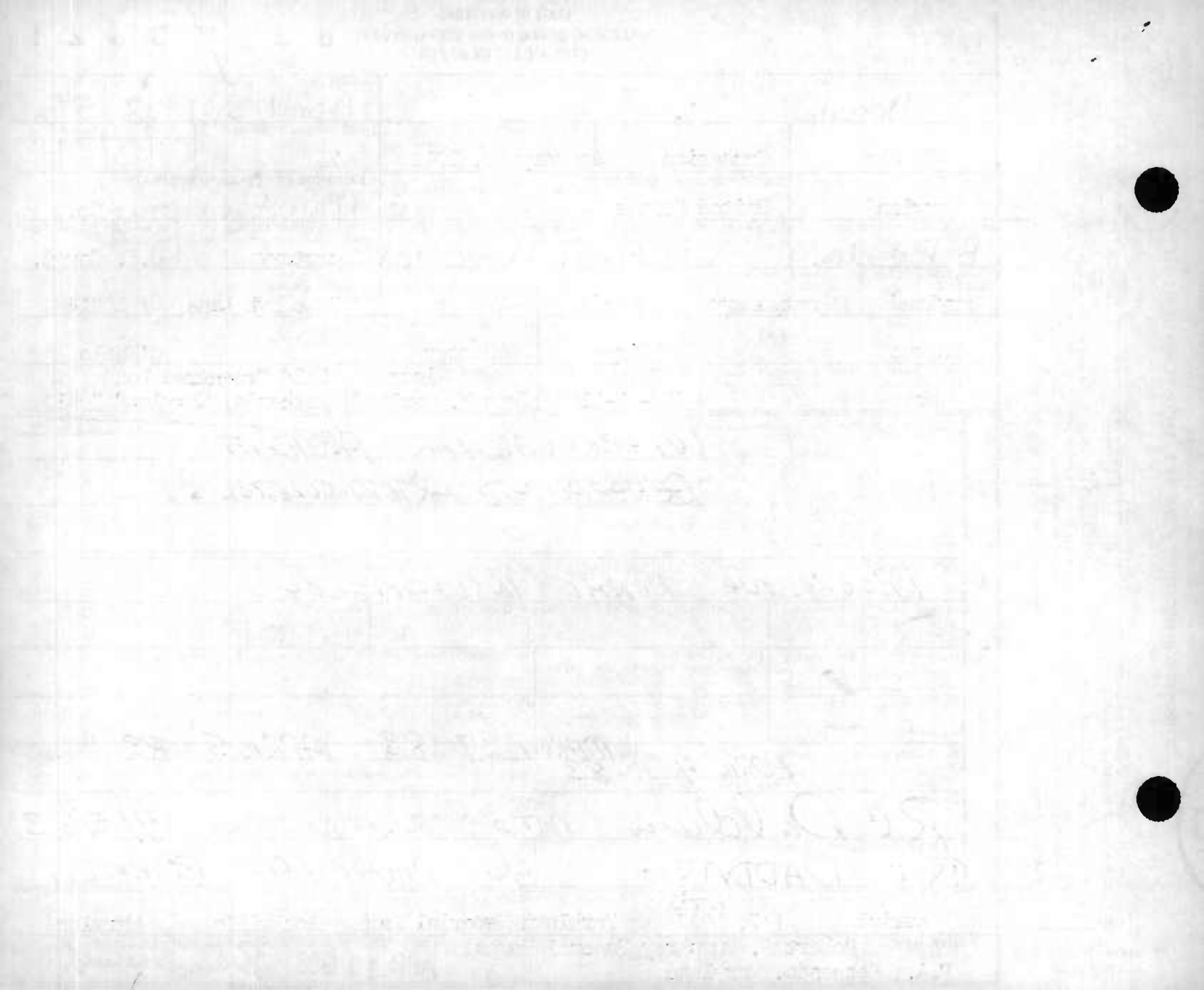
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 3 1 0 8 2 1	
1. FOR STATE REGISTRAR			REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy L. Bowen</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 5, 1983</b>		2b. HOUR <b>545 AM</b>	
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>January 18, 1910</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co., MD.</b>			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Bethesda</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eugene Allison</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Hester O'Neale</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-07-2185</b>		17. INFORMANT <b>Niece June M. Garland</b> ADDRESS <b>7120 Greentree Road Bethesda, Maryland 20817</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GENERALIZED ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>PROGRESSIVE RENAL INSUFFICIENCY</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 27 1983</b> , to <b>APRIL 5 1983</b> , that (I) (we) last saw the deceased alive on <b>APRIL 4 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>R.C. Daddario</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/5/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R.C. DADDARIO</b>		22e. ADDRESS <b>5413 CEDAR LANE BETHESDA</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 7, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>			ADDRESS <b>Funeral Homes, P.A., Bethesda, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 11 1983</b>	
					REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 2 2 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) <b>HERMAN BRAUN</b>				2a. DATE OF DEATH MONTH <b>4</b> DAY <b>15</b> YEAR <b>83</b>		2b. HOUR <b>3:00</b> P <sub>M</sub>	
3. SEX <b>MALE</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>February</b> DAY <b>24</b> YEAR <b>1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Germany</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD	
10. CITY OR TOWN OF DEATH <b>Germantown</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>14905 Spring Meadow Drive</b>		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Chef</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hotel</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Germantown</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST <b>Abraham</b> MIDDLE <b>LAURENCE</b> LAST <b>Braun</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Marie</b> MIDDLE <b>HAAG</b> LAST <b>Haag</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>084-07-6075</b>		17. INFORMANT (Wife) ADDRESS <b>14905 Spring Meadow Drive, Germantown, MD 20874</b> <b>Maria F. Braun</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1509</b> IMMEDIATE CAUSE (a) <b>ESOPHAGEAL CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>2 1/2 MONTHS</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>FEB</b> , 19 <b>83</b> , to <b>MARCH 8</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>MARCH 8</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <b>Eugene P. Flannery</b>		DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/15/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EUGENE P. FLANNERY</b>		22e. ADDRESS <b>18111 PRINCE PHILLIP DR. OLNEY, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>April 16, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>		23d. LOCATION CITY OR TOWN <b>Alexandria</b> COUNTY <b>Virginia</b> STATE <b>Virginia</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Homes, P.A. Rockville, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

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RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C.

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(M)

CHARGE

RECEIVED

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(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 2 3 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST <b>GEORGE HAROLD BREWER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 15 83</b>				2b. HOUR <b>7:07 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 7, 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b>		IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		IF UNDER 24 HRS. HOURS MIN. <b>MD.</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.							
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1208 Autre Court</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supply Officer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CIA</b>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1208 Autre Court 20851</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harry F. Brewer</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alberta Stiffler</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea 181-24-8869</b>		17. INFORMANT ADDRESS <b>Lorraine M. Brewer same as 13e</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC GASTRIC CARCINOMA</b> <b>1519</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>two years</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>March 1981</b> to <b>April 15, 1983</b> , that (I) (we) last saw the deceased alive on <b>January 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.													
22b. SIGNATURE <b>Daniel Rosenblum</b>				DEGREE <b>MD</b> ATTENDING <input checked="" type="checkbox"/> PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4/16/83</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Daniel Rosenblum</b>				22e. ADDRESS <b>10400 Connecticut Avenue Kensington, Md. 20895</b>									
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>4/19/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>				23d. LOCATION CITY OR TOWN STATE <b>Rockville, Maryland</b>					
24. FUNERAL DIRECTOR <b>Lyson Wheeler Funeral Home, Inc.</b> <b>1331 Rockville Pike Rockville, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 20 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 10824 REG. NO. 10824			
I. DECEASED NAME (TYPE OR PRINT) <b>MARY BELLE BRITT</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 - 20 - 1983</b>				2b. HOUR <b>8 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 21 97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD</b>					
10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KENSINGTON GARDENS NURSING CENTER</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOME MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>			
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3 850 Bel Pre Rd. #4</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>PLEASANT COOK BRITT SR.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET HUMPHRIES</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. <b>196-26-1138</b>		17. INFORMANT ADDRESS <b>BROWNFIELD FUN. HOME SMITHFIELD, PA.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>2000</b> <b>DIFFUSE HISTIOCYTIC LYMPHOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 MONTHS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION _____				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST</b> 19 <b>82</b> , to <b>APR 20</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>MAY 20</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Eugene P. Flannery</b>						DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>20 APR 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EUGENE P. FLANNERY, MD</b>						22e. ADDRESS <b>1811 PRINCE PHILIP DR. OLNEY, MD. 20832</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>23 APRIL 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT. MORIAH</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SMITHFIELD FAYETTE PA.</b>			
24. FUNERAL DIRECTOR NAME <b>Paul Seckel</b> ADDRESS <b>Brownfield, Funeral Home Smithfield, PA.</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>			

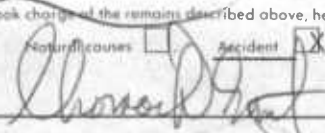
MEDICAL CERTIFICATION





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10825
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Irina Brodsky		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 4 4 1983		2b. HOUR M 5:54P	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 23, 1950	6. AGE (IN YEARS) (LAST BIRTHDAY) 32 YRS.	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 4 1983		2d. HOUR M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baku-U.S.S.R.		7b. CITIZEN OF WHAT COUNTRY? Unknown		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chemist		12b. KIND OF BUSINESS OR INDUSTRY College		
13a. STATE Maryland		13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 345 Congressional Lane (20852)		
14. FATHER'S NAME FIRST MIDDLE LAST Efim Berkovich			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarraz Zalkan			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-94-4532			17. INFORMANT ADDRESS Rockville, Md. 20852 Alexander Brodsky; 345 Congressional Lane							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries</u> 8120 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying</u> cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR <u>4:15</u> P.M. MONTH DAY YEAR 4 4 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver in auto/tractor-trailer impact					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rockville Pike & Strothouse Ave, Rockville, Mont. MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Deputy Chief					DATE SIGNED 4/5/83		
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 7, 83		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Olney; Montgomery; Maryland			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEM. CHAPELS			1170 Rockville Pike; Rockville, Maryland 20852		25a. DATE REC'D BY REGISTRAR APR 11 1983					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 8 2 6 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>William K. Brown, SR.</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4 30 83</i>			2b. HOUR <i>9:45 AM</i>					
3. SEX <i>M</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4 26 07</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>76</i>		7. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD					
10. CITY OR TOWN OF DEATH <i>WHEATON</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Randolph Hills Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>ADV. SALES REP.</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>REAL ESTATE</i>			
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>MONTGOMERY</i>		13c. CITY OR TOWN <i>SILVER SPRING</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1502 CREST ROAD</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>WILLIAM EVERETT BROWN</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>BROWN</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>YES WW II</i>		16b. SOCIAL SECURITY NO. <i>578-09-9250</i>		17. INFORMANT NAME ADDRESS <i>SON 11913 CRESTWOOD AVE., WILLIAM K. BROWN, JR. BRANDYwine, MD. 20611</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>cardiac pulmonary arrest</i> <i>4471</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Multiple cerebral infarct</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>coronary atherosclerosis</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>15 min</i> <i>4 yrs</i> <i>5 yrs</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE <i>9911 Georgia Ave Silver Spring, MD 20902</i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>9 April 83</i> to <i>30 April 83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Merton L. White M.D.</i>			22c. DATE SIGNED <i>30 April 83</i>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Merton L. WHITE, M.D.</i>			22f. ADDRESS <i>9911 Georgia Ave Silver Spring, MD 20902</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>5/3/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARKLAWN CEMETERY</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>ROCKVILLE MONT MD.</i>				
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>			24b. ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>			25. DATE REC'D. BY REGISTRAR <i>MAY 9 1983</i>					

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UNITED STATES GOVERNMENT  
DEPARTMENT OF THE INTERIOR  
BUREAU OF LAND MANAGEMENT



WILLIAM H. HARRIS  
JAN 10 1900  
TO THE  
LAND OFFICE  
WASHINGTON, D. C.

THE LAND OFFICE  
WASHINGTON, D. C.



100%  
COLLECTED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 2 7 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) Terrance E Browning				2a. DATE OF DEATH MONTH DAY YEAR 4 15 83			
3. SEX MALE				2b. HOUR 4:17 AM			
4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 3 5 55		6. AGE (IN YEARS LAST BIRTHDAY) 28 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A	
12b. KIND OF BUSINESS OR INDUSTRY		13a. STREET ADDRESS QUEEN ANNES DRIVE 8412 Queen Anne Dr. 20910		13b. CITY OR TOWN SILVER SPRING		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS G. BROWNING		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST M. BERNADETTE McKENZIE		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 216-64-1865	
17. INFORMANT ADDRESS FRANCIS G. BROWNING SAME AS 13 FATHER		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 2500 DUE TO, OR AS A CONSEQUENCE OF (b) CHRONIC RENAL FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) ADVANCED DIABETES MELLITUS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: N.A.							
19a. DATE OF OPERATION N.A.		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED N.A.		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2) N.A.		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N.A. N.A. N.A. N.A.		21g. I certify that (I) (this hospital) attended the deceased from above, (I) (we) did not view the body after death.		21h. I certify that (I) (this hospital) attended the deceased from above, (I) (we) did not view the body after death.	
22a. SIGNATURE V.C. WEIDIG M.D.		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/16	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) V.C. WEIDIG M.D.		22e. ADDRESS SUITE 272, 14805 PHYSICIANS RD. ROCKVILLE, MD.		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/18/83	
23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.		24. FUNERAL DIRECTOR FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25. REC'D. BY REGISTRAR APR 21 1983	
25. REGISTRAR'S SIGNATURE John J. Conner							

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*Handwritten notes on the right margin, including '100' and '100'.*

20% COLL



APR 21 1963

*Handwritten signature or name at the bottom left.*



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M/7/77

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										3		REG. NO. 1 0 8 2 8									
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE KNOWN OF DEATH					ESTIMATED					2b. HOUR											
Jay C. Bryant										April 10 1983										11:18 AM											
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD					2d. HOUR													
Male		Cauc.		Feb. 6, 1905			28 YRS.		MONTHS DAYS		HOURS MIN		April 10 1983					11:18 AM													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?					8. MARRIED					9. BALTIMORE CITY OR COUNTY OF DEATH					MD.											
Pennsylvania					United States					WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					Montgomery County																
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY					U.S.											
Silver Spring					15401 Bassett Lane #2C					Biochemist					Government																
13a. STATE										13b. COUNTY										13c. STREET ADDRESS										(20906)	
Maryland										Montgomery										15401 Bassett Lane #2C											
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					16. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS											
Clayton					Bryant					Mary					Tallman																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?					16b. SOCIAL SECURITY NO.					17. INFORMANT					ADDRESS																
No					216-44-6764					Jean B. Bryant, same as #13																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 1 DEATH WAS CAUSED BY:																															
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis.</u>																															
4291 } DUE TO, OR AS A CONSEQUENCE OF																															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.																															
(b) <u>Chronic Myocardial Dis.</u>																		Yrs.													
DUE TO, OR AS A CONSEQUENCE OF																															
(c)																															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																															
None																															
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?																					
None										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																					
					HOUR A.M. MONTH DAY YEAR																										
					P.M. 19																										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION																					
										STREET					CITY OR TOWN COUNTY STATE																
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																															
ACTUAL SIGNATURE										TITLE (SPECIFY)										DATE SIGNED											
John S. Rogers, M.D.										M.D. Dep.										4/10/83											
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS																					
John S. Rogers, M.D.										1919 Seminary Road Silver Spring, Maryland 20910																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION																
Burial					April 13, 1983					Parklawn Mem. Park					Rockville, Maryland																
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR										25b. REGISTRAR'S SIGNATURE											
Robert A. Bumphrey Funeral Homes, P.A. Bethesda, Maryland 20814										APR 13 1983										John J. [Signature]											



STANDARD OF EXCELLENCE  
MEDICAL EXAMINING & TESTING SERVICE



Cheng Hsueh-shan  
Member of the

DATE

100% COMPLETE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DHMH - 17  
(VR A15 ME (S))  
15M 7/77

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10829	
1. DECEASED NAME (TYPE OR PRINT) <b>Clifford A. Burchsted</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>Apr. 8 1983</b>										2b. HOUR <b>1022 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>Cauca</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 19, 1921</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>61</b> YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD <b>April 8 19 83</b>		2d. HOUR <b>1022 AM</b>							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>				MD.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Engineer Union</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Carbide</b>									
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Tennessee</b> 13b. COUNTY <b>Anderson</b> 13c. CITY OR TOWN <b>Clinton</b>										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>710 River Bend Road 37716</b>									
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles F. Burchsted</b>										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Emma Corey</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b> (IF YES, GIVE WAR OR DATES) <b>WWII</b>				16b. SOCIAL SECURITY NO. <b>024 16 8522</b>		17. INFORMANT <b>Wife</b> ADDRESS <b>Elizabeth S. Burchsted Same as 13</b>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAL INFARCTION</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>CORONARY ARTERIOSCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>INDEX</b>														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b>							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																					
19a. DATE OF OPERATION <b>—</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>—</b>								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8:30 A.M. 8/8/83</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>COLLAPSED WALKING UP STAIRS</b>													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>20900 GERMANTOWN RD GERMANTOWN MONT. MD</b>													
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																					
ACTUAL SIGNATURE <i>Francis C. Mayle</i>				TITLE (SPECIFY) <b>Deputy</b>				DATE <b>April 8, 1983</b>				MEDICAL EXAMINER SIGNED									
EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C. Mayle, M.D.</b>				ADDRESS <b>8200 Wisconsin Ave. Bethesda, Md</b>																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>				23b. DATE <b>April 9, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria, Virginia</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>— — — —</b>											
24. FUNERAL DIRECTOR NAME ADDRESS <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b>				25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>													

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RECEIVED BY THE DIRECTOR OF THE BUREAU OF THE CENSUS



CHIEF OF BUREAU



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10830

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST		MONTH DAY YEAR		M	
Harriet B. BURG		April 4, 1983		7:00 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	41 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New York	USA		Montgomery County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Silver Spring	Holy Cross Hospital	Attorney	Law		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Washington, D.C.		--	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20015 3617 Patterson St. NW	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	ADDRESS			
FIRST MIDDLE LAST	FIRST MIDDLE LAST				
Abraham Bisgaier	Gladys Rosenberg				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS		
no	068-34-3041	Gerald E. Burg	3617 Patterson St. NW Washington, DC 20015		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. (IMMEDIATE CAUSE (a))			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
1552 Hepatic Failure & Gastrointestinal bleeding			1 day		
DUE TO, OR AS A CONSEQUENCE OF (b) Hepatic Metastases			few months		
DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma of Breast			4 1/2 yrs.		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 10					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from Sept. 25, 1982, to April 4, 1983, that (I) (we) lost saw the deceased alive on April 4, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE G. Lennard Gold M.D.		22c. DATE SIGNED 4/5/83		22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Lennard Gold, M.D.	
		22e. ADDRESS 8630 Fenton St. #230 Silver Spring MD 20910			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial	4/6/83	Judean Mem. Gardens		Olney, Montgomery, MD	
24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE			
Warner E. Pumphrey, Inc.	APR 8 1983	John J. Connel			



3

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1 0 8 3 1

1. DECEASED NAME (TYPE OR PRINT) <b>Mary HELEN Burgess</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>04</b> DAY <b>13</b> YEAR <b>1983</b>			2b. HOUR <b>8:10 PM</b>		
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH <b>April</b> DAY <b>28</b> YEAR <b>1929</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>53</b> YRS.	IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>	2c. DATE PRONOUNCED DEAD MONTH <b>4</b> DAY <b>13</b> YEAR <b>1983</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>home</b>
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Germantown</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>11412 Scenery Place 20874</b>		
14. FATHER'S NAME FIRST <b>Rush</b> MIDDLE <b>P.</b> LAST <b>Lawrence</b>			15. MOTHER'S MAIDEN NAME FIRST <b>Ethel</b> MIDDLE <b>Hardy</b> LAST <b>Hardy</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-36-1029</b>		17. INFORMANT <b>Gaithersburg, Md. 20877</b> <b>Thomas B. Burgess 203 Lee St. #5</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>5715 hepato renal syndrome</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>cirrhosis of liver</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>chronic alcohol addiction</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>John Tauber</b>			TITLE (SPECIFY) <b>M.D.</b>			MEDICAL EXAMINER <b>DATE SIGNED 4-13-83</b>		
EXAMINER'S NAME (TYPE OR PRINT) <b>John Tauber</b>			ADDRESS <b>8218 Wisconsin Ave.</b>					
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>			23b. DATE <b>4/18/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>		23d. LOCATION CITY OR TOWN <b>Rockville, Maryland</b> COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>					25a. DATE REC'D. BY REGISTRAR <b>APR 20 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Church</b>			



APR 30 1953  
James Smith



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please move it to the back of the folder with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DHMH - 16 50M 1/81  
(VRA 15.4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 3 2 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Dessie H. Burke</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>April 18, 1983</b>		2b. HOUR <b>4:10P.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>March 4, 1910</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Hyattsville</b>		13c. STREET ADDRESS <b>1402 Chillum Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Henry Mitts</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ottie Orebaugh</b>		16. SOCIAL SECURITY NO. <b>579-12-3859</b>	
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		17b. SOCIAL SECURITY NO. <b>579-12-3859</b>		17. INFORMANT ADDRESS <b>Mrs. Sue Carol Dodd 9131 Alcona Street Lanham, Md. 20706</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1539 Hepatic Insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>metastatic Colon Cancer</b> DUE TO, OR AS A CONSEQUENCE OF: (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>18 months</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from <b>15 JUL 82</b> to <b>18 April 83</b> , that (2) we lost saw the deceased alive on <b>18 April 83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did not) view the body after death.					
22b. SIGNATURE <b>Thomas A. Beasly</b>				22c. DATE SIGNED <b>4/19/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas A. Beasly MD</b>				22e. ADDRESS <b>2676 New Hampshire Ave Langley Park MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 21, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	
23d. LOCATION CITY OR TOWN <b>Brentwood</b>		23e. COUNTY <b>P.G., Maryland</b>		23f. ZIP CODE <b>20883</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>F. Gasch's Sons F.H. P.A. Hyattsville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 20 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>				25c. REGISTRAR'S NAME <b>John J. Carver</b>	



*[Faint, mostly illegible text and markings covering the majority of the page, possibly bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10833  
REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EVA M Burriss			2a. DATE OF DEATH MONTH DAY YEAR 4 27 83			2b. HOUR 1056AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 11 15		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY -	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Dickerson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 18414 Comas Road		13f. CITY OR TOWN 20763		13g. STREET ADDRESS 18414 Comas Road		13h. CITY OR TOWN 20753	
4. FATHER'S NAME FIRST Harry L. MIDDLE Neisser LAST		15. MOTHER'S MAIDEN NAME FIRST Eva M. MIDDLE Rumpf LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220-10-5909	
16c. SOCIAL SECURITY NO. 220-10-5909		17. INFORMANT Mr. Horace C. Burriss Rd. Dickerson, Maryland		17a. ADDRESS 18414 Comas Road		17b. CITY OR TOWN 20753	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Post-anoxic encephalopathy minutes DUE TO, OR AS A CONSEQUENCE OF (c) Myocardial Infarction 4 days		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.			

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4-23, 1983, to 4-27, 1983, that (I) (we) last saw the deceased alive on 4-27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert Bayer		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-27-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT BAYER		22e. ADDRESS 5654 SHIELDS DR. BETHESDA, MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr 30, 1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery Frederick Frederick Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR Sharon Keeney-Basford P.A. Funeral Home		25a. DATE REC'D. BY REGISTRAR MAY 2 1983		25b. REGISTRAR'S SIGNATURE John J. Grier			
106 E. Church St., Frederick, Md. 21701							



BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

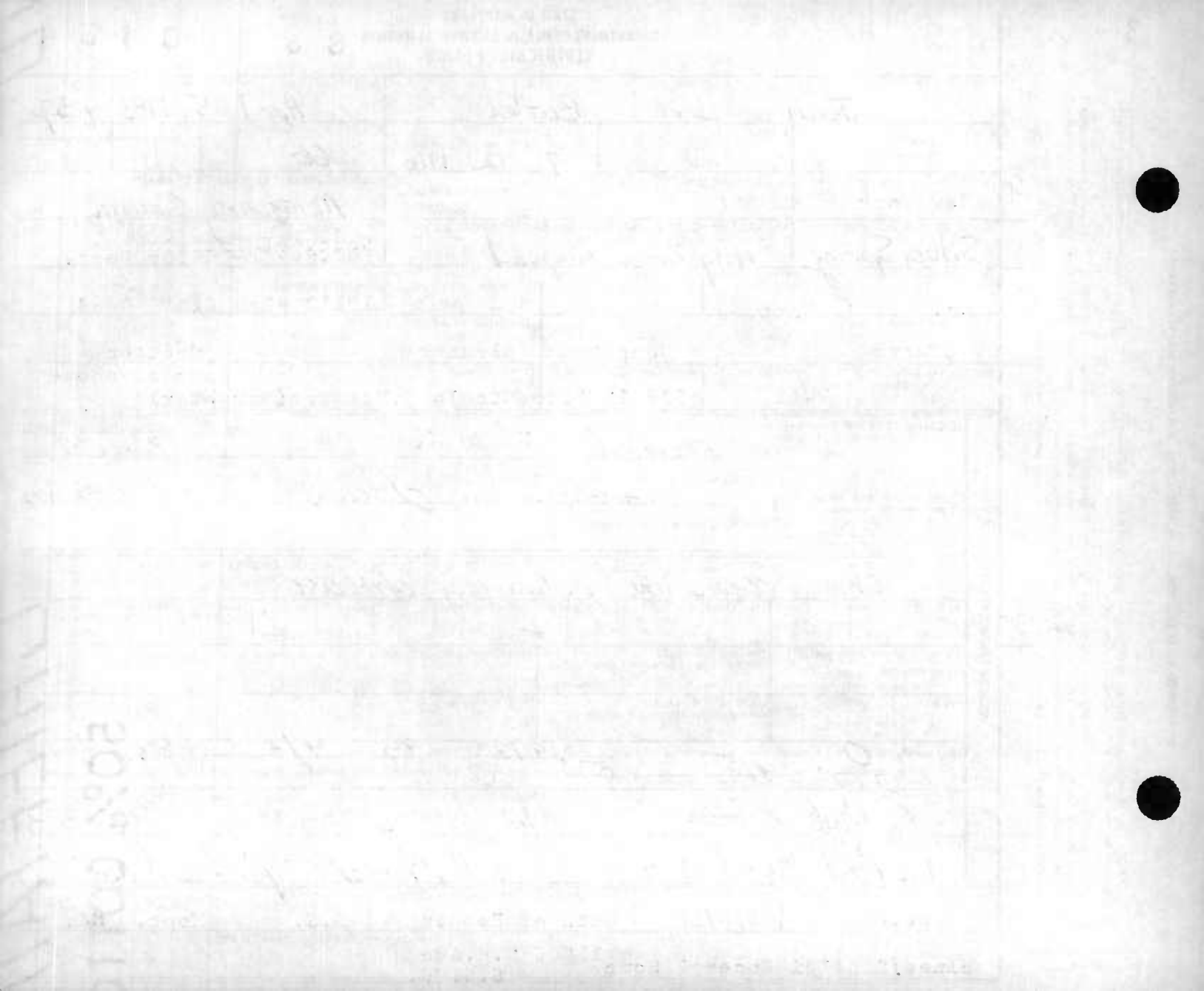
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR					8 3 1 0 8 3 4 REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) Jean H. Butler					2a. DATE OF DEATH MONTH DAY YEAR April 5, 1983					2b. HOUR 9:30 PM	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 7 12 1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.			IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (IF WORK FOR MOST OF WORKING LIFE, INDUSTRY) Fed. Gov't Editor Dept.			12b. KIND OF BUSINESS OR		
13a. STATE Md.				13b. COUNTY Mont.		13c. CITY OR TOWN Olney		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20832 19113 Bloomfield Road	
14. FATHER'S NAME FIRST MIDDLE LAST Edward B. Houghton				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eleanor Wootton				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes WWII			
16b. SOCIAL SECURITY NO. 579 12 8315				17. INFORMANT Nicola B. McKenna (Daughter)				ADDRESS Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>cerebro-vascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic obstructive pulmonary disease</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks 10y standing	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic obstructive pulmonary disease</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>3/9/83</u> , 19 <u>83</u> , to <u>4/3</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>4/3</u> , 19 <u>83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If "X" is checked, I (we) did not view the body after death.)											
22b. SIGNATURE La Paul Kretzing				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/6/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) La Paul Kretzing				22e. ADDRESS 18111 Prince Philip Rd. Olney, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4/8/83		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven			23d. LOCATION CITY OR TOWN COUNTY STATE S.S. Mont. Md.			
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home				ADDRESS 11800 N.H. Ave S.S. Md.				25a. DATE REC'D. BY REGISTRAR APR 11 1983		25b. REGISTRAR'S SIGNATURE John J. Lamer	





1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 3 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>MARJORIE Elinor CABRAL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-27-83</b>			2b. HOUR <b>1:10 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 26 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
11. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary/Gov't</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Aquarium Bermuda</b>	
13a. STATE <b>PAGET, BERMUDA</b>		13b. COUNTY		13c. CITY OR TOWN <b>St. Michael's Road</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <b>Jeffrey C</b>		15. MOTHER'S MAIDEN NAME <b>Elinor Graves</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>017-20-9683</b>		17. INFORMANT ADDRESS <b>Mr. Emory Cabral, Husband, Same as item #13</b>					

## 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

**2001**IMMEDIATE CAUSE (a) **LYMPHO SARCOMA**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**9 years**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/9</b> , 19 <b>83</b> , to <b>4/27</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>4/26</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Kirkland C. Brace</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/27/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KIRKLAND C. BRACE</b>		22e. ADDRESS <b>1600 CARROLL AVE TAKOMA PARK, MD</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>April 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Georges Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>BERMUDA</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes,</b> <b>P.A., Bethesda, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 2 1983</b>			



CR-107-00

DATE: 10/10/70  
BY: [Signature]

(M)

11/11/70

50% COI

(M)

10/10/70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If the deceased was 4 months of age or older, the death certificate must be signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 8 3 6	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET ESTELLE CAMMER						2a. DATE OF DEATH MONTH DAY YEAR APRIL 15 1983			2b. HOUR 10:15 <sup>a</sup> M		
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH DECEMBER 19 1921		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.			7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES CLERK		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE CITY OR TOWN S. CAROLINA CHARLESTON						13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS 3855 CHISOLM ROAD 99999			
14. FATHER'S NAME FIRST MIDDLE LAST Archie Allen Smith				15. MOTHER'S MAIDEN NAME FIRST MIDDLE ESTELLE BROWNLEE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO		16b. SOCIAL SECURITY NO. 248-16-6127		17. INFORMANT JOAN C. SMITH		ADDRESS 3859 CHISOLM ROAD 29455 JOHN'S ISLAND, S. CAROLINA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) METASTATIC BREAST CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 20 MARCH 1983 to 15 APRIL 1983, that (I) (we) last saw the deceased alive on 15 APRIL 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael S. Gurney				DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/15/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL S. GURNEY, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/19/83		23c. NAME OF CEMETERY OR CREMATORY Bethany Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Charleston. S.C.				
24. FUNERAL DIRECTOR NAME ADDRESS C. M. Howell Arlington, Va.				DATE REC'D. BY REGISTRAR APR 25 1983		25. REGISTRAR'S SIGNATURE Joan C. Smith					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 3 1 0 8 3 7 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Dorothy C. Carr				2a. DATE OF DEATH MONTH DAY YEAR April 4, 1983		2b. HOUR 10:02AM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR July 18 1904		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. U.S. Gov.		12b. KIND OF BUSINESS OR INDUSTRY Cryptographer	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.				13b. COUNTY Anne Arundel		13c. CITY OR TOWN Edgewater	
14. FATHER'S NAME FIRST MIDDLE LAST William J. Erhart				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Kither			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 108-16-2610		17. INFORMANT ADDRESS Barbara R. Schwier-Ct., Falls Church, Va. 22040			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 6826 IMMEDIATE CAUSE (a) SEPTICEMIA WITH CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).							
19a. DATE OF OPERATION 3/30/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ARTHROTOMY OF DTHIP FOR ACCESS		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 17, 1983, to April 4, 1983, that (I) (we) lost saw the deceased alive on April 4, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.							
22b. SIGNATURE Eugene P. Flannery		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/4/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene Flannery, M.D.		22e. ADDRESS 18111 Prince Philip Drive Olney, Maryland 20832					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/7/1983		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Geo. Md.	
24. FUNERAL DIRECTOR NAME Valley's F.H. Inc.		ADDRESS Mt. Rainier, Md.		25a. DATE REC'D. BY REGISTRAR APR 11 1983		25b. REGISTRAR'S SIGNATURE [Signature]	

®

signed for Dr. Thomas Ward

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M (1/8)  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1 - FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Odell Roosevelt Carr					2a. DATE OF DEATH MONTH DAY YEAR April 1, 1983			2b. HOUR 8:25 P.	
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 12 04 1917		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.			
10. CITY OR TOWN OF DEATH Gaithersburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hos.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Minister		12b. KIND OF BUSINESS OR INDUSTRY Religion	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Dickerson		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21020 Beallsville Road 20842	
14. FATHER'S NAME FIRST MIDDLE LAST Jospeh Carr					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mamie Fields				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 287-18-6987		17. INFORMANT ADDRESS Alice Carr, 21020 Beallsville Road, Dickerson, Md. 20842					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>(Brain stem) cerebrovascular accident</u> 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH March 1983
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) see the body after death.									
22b. SIGNATURE 				DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/2/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSOOTH LEKAGUL, MD				22e. ADDRESS 7425 arlington Rd. Bethesda Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/6/83		23c. NAME OF CEMETERY OR CREMATORY Resthaven Mem. Gar.		23d. LOCATION CITY OR TOWN COUNTY STATE Frederick, Frederick, Md.			
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer				1621 Opossumtown Pike Frederick, MD. 21701		25a. DATE REC'D. BY REGISTRAR APR 11 1983			
25b. REGISTRAR'S SIGNATURE 									

MEDICAL CERTIFICATION



APR 1 1963  
John G. Smith



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the office of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

1 0 8 3 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Harry Leonard Carter			2a. DATE OF DEATH MONTH DAY YEAR April 25, 1983			2b. HOUR p 5:30 M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 31, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		9. CITIZEN OF WHAT COUNTRY? United States		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
12. CITY OR TOWN OF DEATH Bethesda		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH Clinical Center, Bethesda, Md.				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator		15. KIND OF BUSINESS OR INDUSTRY Machinery		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE Virginia			16b. COUNTY Bedford		16c. CITY OR TOWN Blue Ridge		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS Route 1, Box 239 zip 24064	
17. FATHER'S NAME FIRST MIDDLE LAST Earl Carter			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nora Dooley							
19a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) Yes			19b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII 155-18-4868			20. INFORMANT ADDRESS Mrs. Mary L. Carter (wife) Same as patient				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

4254 IMMEDIATE CAUSE (a) Cardiogenic Shock

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

1/2 hour

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.(b) DUE TO, OR AS A CONSEQUENCE OF  
Cardiomyopathy

Several years

(c) DUE TO, OR AS A CONSEQUENCE OF  
Aortic Stenosis/insufficiency

Several years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION April 25, 1983		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Aortic Stenosis		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from April 23, 1983, to April 25, 1983, that (we) lost saw the deceased alive on April 25, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (do not) view the body after death.							
22b. SIGNATURE Warren Glover				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 4/25/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WARREN GLOVER				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/Removal		23b. DATE 1983 April 26		23c. NAME OF CEMETERY OR CREMATORY Cool Springs Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cool Springs, Bedford, Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey, Funeral Homes, Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR APR 26 1983			



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Samuel Caruso</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR <b>4/28 19 83</b>		2b. HOUR <b>9:40 P.</b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Jul. 7, 1945</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>37 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR) <b>Washington, DC</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> <del>XXXXXXXXXX</del> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Olney</b>	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK) <b>School Board</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Derwood</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>7249 Mill Run Drive</b>
14. FATHER'S NAME <b>Frank</b>		15. MOTHER'S MAIDEN NAME <b>Mary</b>		<b>Verardo</b>
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>yes 1963-1965</b>		16b. SOCIAL SECURITY NO. <b>217-42-2080</b>		17. INFORMANT <b>2014 Georgia Ave., Mary Caruso-mother- Sil. Spr. Md. 20902</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b> 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Coronary Artery Disease</b> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>				
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .				
ACTUAL SIGNATURE <i>John S. Rogers</i>		TITLE (SPECIFY) <b>M.D.</b>		DATE SIGNED <b>4/28/83</b>
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>		ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (15) <b>Burial</b>	23b. DATE <b>5-2-1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>	23d. LOCATION <b>Silver Spring Montgomery Md.</b>	
24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home</b>		ADDRESS <b>11800 N.H. Ave. Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b>
		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>		



1919 Summary Book  
Given Office, Kentucky, No.

4-25-19

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 4 1 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) <sup>FIRST</sup> <u>WALTER</u> <sup>MIDDLE</sup> <u>S. S.</u> <sup>LAST</sup> <u>CHAIN</u>				APRIL 28 1983 7:45 M			
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH <sup>MONTH</sup> <u>NOVEMBER</u> <sup>DAY</sup> <u>25</u> <sup>YEAR</sup> <u>1889</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>93</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>RUSSIA</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY COUNTY</u> MD.	
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>WOMEN'S APPAREL</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>MERCHANT</u>	
13a. STATE <u>MARYLAND</u>		13b. COUNTY <u>MONTGOMERY</u>		13c. CITY OR TOWN <u>KENSINGTON</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <u>MORRIS</u> MIDDLE <u>CHAIN</u>		15. MOTHER'S MAIDEN NAME <u>ANNA</u> MIDDLE <u>COHEN</u> SUFFIX <u>ST</u>		13e. STREET ADDRESS <u>10231 CARROLL PLACE</u> <u>20895</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <u>NO</u>		16b. SOCIAL SECURITY NO. <u>196-03-3136</u>		17. INFORMANT <u>EDWARD A. CHAIN, SHEFFIELD B-33, WEST PALM BEACH, FLORIDA</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure due to arteriosclerosis 2 weeks</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>cardiovascular &amp; cerebrovascular disease 5 years</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Emphysema and diabetes</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, INDICATE MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) <u>my</u> hospital attended the deceased from <u>4-27</u> 19 <u>83</u> to <u>4-28</u> 19 <u>83</u> that (1) <u>was</u> last seen alive on <u>4-27</u> 19 <u>83</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. If (a) <u>did not</u> view the body after death.							
22b. SIGNATURE <u>[Signature]</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4-28-83</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dawn Geiger, M.D.</u>		22e. ADDRESS <u>PP30 CAMERON STREET SILVER SPRING, MD. 20910</u>					
23a. BURIAL, CREMATION, REMOVAL (15) <u>BURIAL</u>		23b. DATE <u>5/1/1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>KING DAVID MEMORIAL GARDEN</u>		23d. LOCATION (CITY OR TOWN) <u>FALLS CHURCH, VIRGINIA</u>	
24. FUNERAL DIRECTOR <u>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</u> 232 CARROLL STREET, N. W., WASHINGTON, D. C.				25a. DATE REC'D. BY REGISTRAR <u>MAY 3 1983</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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BOX 20000



Jan 10 1941



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 19 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

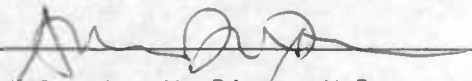

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 10842			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST GARRY ALEXANDRIA CHAMP JR.				APRIL 14 1983 10:06a			
3. SEX MALE		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR DECEMBER 18 1982		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 3 26	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE VIRGINIA 13c. COUNTY FAUQUIER 13d. CITY OR TOWN MIDLAND				13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13f. STREET ADDRESS ROUTE 1, BOX 140 99999			
14. FATHER'S NAME GARRY ALEXANDRIA CHAMP SR.				15. MOTHER'S MAIDEN NAME SHARON DEBBIE MCDONALD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT ADDRESS ROUTE 1, BOX 140 GARRY A. CHAMP SR. MIDLAND, VA 22728			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO/RESPIRATORY ARREST RESPIRATORY INSUFFICIENCY							
7429							
DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE ENCEPHALOPATHY							
DUE TO, OR AS A CONSEQUENCE OF (c) Respiratory arrest, cause unclear.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 8 FEBRUARY 83, to 14 APRIL 83, that (I) (we) lost saw the deceased alive on 14 APRIL 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE M. K. KOZEL, LT, MC, USNR				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 14 APR 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. K. KOZEL, LT, MC, USNR				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 18 1983		23c. NAME OF CEMETERY OR CREMATORY Warrenton		23d. LOCATION CITY OR TOWN Warrenton, Fauquier, VA.	
24. FUNERAL DIRECTOR NAME G. W. JOYNES				25a. DATE REC'D. BY REGISTRAR APR 21 1983		25b. REGISTRAR SIGNATURE	
24. FUNERAL HOME NAME Joyne's Funeral Home - Warrenton, VA.				25b. REGISTRAR SIGNATURE			





*[Faint handwritten notes at the bottom of the page]*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Item #15 Film G579 5/19/83 rc FOR #15, Film G580 6/3/83 kam DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH 3										REG NO. 10843	
1. DECEASED NAME (TYPE OR PRINT) <b>ALAN CHAVIS</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR <b>4 30 1983</b>		2b. HOUR <b>M</b>			
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 1 1956</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>26 YRS.</b>	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4 30 1983</b>	2d. HOUR <b>10:16</b>		<b>D M</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CONSTRUCTION WORKER</b>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>KENSINGTON</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET ADDRESS <b>3002 FINDLEY ROAD 20895</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>ANDREW VARDELL CHAVIS</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DOROTHY Osterman AOSTERMAN</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>219-68-3797</b>		17. INFORMANT ADDRESS <b>ANDREW V. CHAVIS SAME AS 13 FATHER</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>9654</b> IMMEDIATE CAUSE (a) <b>Gunshot wound of chest (unspecified weapon)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MIN MONTH DAY YEAR <b>9:30 P.M. 4-30- 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Subject shot.</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>parking lot</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Ennals Ave. Silver Spring, Mont. Md.</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 					TITLE (SPECIFY) <b>M.D. Assistant</b> MEDICAL EXAMINER			DATE SIGNED <b>5-1-83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Ann M. Dixon, M.D.</b>					ADDRESS <b>111 Penn St., Balto., Md. 21201</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/4/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>PARKLAWN CEMETERY</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>ROCKVILLE MONT MD.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 6 1983</b>		25b. REGISTRAR'S SIGNATURE 				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be advised at once.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 4 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) LEE Wai Cho			2a. DATE OF DEATH MONTH DAY YEAR April 14, 1983			2b. HOUR 7:30p M				
3 SEX Male		4. RACE Chinese 4		5. DATE OF BIRTH MONTH DAY YEAR June 5, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Canton, China		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2417 Lillian Dr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Laundry Owner		12b. BUSINESS OR INDUSTRY Laundry		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2417 Lillian Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Lee Ting Nai			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lee Shee							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. None		17. INFORMANT Silver Spring, Md. 20902 Fatt Mon Lee-son 2417 Lillian Dr.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4409 IMMEDIATE CAUSE (a) <u>Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>old Age</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22. I certify that (I) (the hospital) attended the deceased from <u>6-12</u> , 19 <u>81</u> , to <u>4-14</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>2-4</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Edmond Richards</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4-15-83	
22a. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 17, 1983		23c. NAME OF CEMETERY OR CREMATORY George Wash. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Md.			
24. FUNERAL DIRECTOR NAME Lee Funeral Home			ADDRESS 300-4th St. N.E. Wash. D.C. 20002			25a. DATE REC'D BY REGISTRAR APR 25 1983		25b. REGISTRAR'S SIGNATURE <u>John F. Canfield</u>		

CONFIDENTIAL

1. Name: [illegible]  
2. Address: [illegible]  
3. City: [illegible]  
4. State: [illegible]  
5. Zip: [illegible]  
6. Date: [illegible]  
7. Signature: [illegible]  
8. Title: [illegible]



1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]  
6. [illegible]  
7. [illegible]  
8. [illegible]  
9. [illegible]  
10. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
Item 4 4-25-83 cn 1- FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) Peter J. Cinotti					2a. DATE OF DEATH MONTH DAY YEAR 4 17 83			2b. HOUR 9:45 A.M.	
3. SEX M		4. RACE C White		5. DATE OF BIRTH MONTH DAY YEAR 10 19 35		6. AGE (IN YEARS LAST BIRTHDAY) 47		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7c. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY CITY MD.			
10. CITY OR TOWN OF DEATH MONTGOMERY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALES		12b. KIND OF BUSINESS OR INDUSTRY DISTRIBUTING	
13a. STATE MD					13b. CITY OR TOWN MONTGOMERY SILVER SPRING		13c. STREET ADDRESS 21 Featherwood CT 20910		
14. FATHER'S NAME FIRST MIDDLE LAST FRANK T. CINOTTI					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CECILIA M. WOODS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) XXXXXXX 1958-1964					16b. SOCIAL SECURITY NO. 579-46-1037		17. INFORMANT Evelyn Cinotti WIFE 21 Featherwood CT Silver Spring MD 20910		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) <u>Intestinal Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe Coagulopathy</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cirrhosis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 6, 1982, to 4-17, 1983, that (I) (we) last saw the deceased alive on 4-17, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Steven A. Burger					DEGREE MD			22c. DATE SIGNED 4-17-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven A. Burger					22e. ADDRESS 2101 Medical Park Dr. Silver Spring, Md				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4/20/83		23c. NAME OF CEMETERY OR CREMATORY FORT LINCOLN CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE BRENTWOOD PRI GEO MD.		
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901					25a. DATE REC'D. BY REGISTRAR APR 21 1983				



TO THE SECRETARY OF AGRICULTURE  
WASHINGTON, D. C.

FROM THE SECRETARY OF AGRICULTURE  
WASHINGTON, D. C.

RE: [Illegible]

[Illegible text follows, appearing to be a memorandum or official communication.]

NOTICE





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 10846 REG. NO.							
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR P M			
1. DECEASED NAME FIRST MIDDLE LAST MARGARET KATHLEEN CLARDY				APRIL 19 1983				9:35 P M			
3. SEX FEMALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR JUNE 4 1915		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MISSISSIPPI		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S. NAVY			
13a. STATE DISTRICT OF COLUMBIA				13b. CITY OR TOWN Washington, DC		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1719 19th STREET, NW 99999			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH ANDREW CLARDY				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET JOSEPHINE FRIDAY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 1943-1964 425-09-1353		17. INFORMANT ADDRESS CHARLES H. CRIGLER, 1719 19th STREET, NW, WASHINGTON, DC 20009					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 METASTATIC BREAST CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from APRIL 14 1983, to APRIL 19 1983, that (I) (we) last saw the deceased alive on APRIL 19 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE R. L. Sollock wck/mc				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 21 APR 83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. L. SOLLOCK, LCDR, MC, USN				22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 4-21-1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Prince Geo., Md			
24. FUNERAL DIRECTOR (NAME) W. W. Chambers Co, Inc 8655 Georgia Ave Silver Spring, Md. 20910						25a. DATE RECD. BY REGISTRAR APR 25 1983		25b. REGISTRAR'S SIGNATURE John J. Canfield			

STANDARD



11-1-1933 (Central Hill, New York, England, since 1900)  
T. J. Campbell Co., Inc. 1933-1934  
River, N.Y. 1934

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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BP

DHMH - 16 50M 1/BI  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10847  
REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST ALVIN M. CLARK		MONTH DAY YEAR APRIL 16 '83		11:20 A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
M	B	MONTH DAY YEAR 10 20 09	73 YRS	MONTHS DAYS	HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
OHIO	USA		MONTGOMERY CTY. MD		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
SILVER SPRING	HOLY CROSS HOSPITAL		Doorman		VAN NESS APTS.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?	13c. STREET ADDRESS		
13a. STATE COUNTY CITY OR TOWN MD MONTGOMERY BETHESDA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	5721 GROSSNER LANE 20814		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Bert A. Clark		Nellie M. Haithock			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		577-10-9403		MARTHA FITZGERALD 404 Rittenhouse ST. Washington DC	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) Cardiorespiratory arrest					
4292 DUE TO, OR AS A CONSEQUENCE OF, Congestive Heart Failure					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF, Severe atherosclerotic disease					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
Embolus to right arm					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
4/15/83		Embolus right arm		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		HOUR A.M. MONTH DAY YEAR P.M. 19			
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4/15/83 to 4/16/83, that (I) (we) last saw the deceased alive on 4/15/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Barry J. Levin MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		4/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
BARRY J. LEVIN MD		4801 MASS AVE, WASH. D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		April 22, 1983		Maryland National Cemetery Laurel, Md.	
24. FUNERAL DIRECTOR NAME		APR 21 1983		John J. Lewis	
Stewart		Funeral Home-4001 Benning Road, N.E.			

DOOR ON

Text

no

General Home-1001 Benning Road, N.W.  
APR 24 1963  
National Cemetery, Laurel, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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Items #13e, 16b&17 Film G578 4/13/83 STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. 83 10848

1. DECEASED NAME (TYPE OR PRINT) MONROE A. CLAY		2a. DATE OF DEATH MONTH DAY YEAR 4 6 83		2b. HOUR 4:04PM
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 11 13 18		6. AGE (IN YEARS LAST BIRTHDAY) 64
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE M		13b. COUNTY	13c. CITY OR TOWN Wash D.C.	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST William H. Clay		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Callie Morrison		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes yes		16b. SOCIAL SECURITY NO. 226-10-0177 578 03 9401		
17. INFORMANT ADDRESS Mrs. Romayne B. Clay-wife-3001 Veazey Terrace, N.W. Washington, D.C. Apt. 725				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiopulmonary arrest</u> 5850 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic renal failure</u> 2 mos.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension</u>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>3/28/83</u> 19 <u>83</u> , to <u>4/6</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>3/28</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Robert L. Curran MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/6/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT L. CURRAN MD		22e. ADDRESS 4805 DELRAY AVE. BETHESDA, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 9, 1983		23c. NAME OF CEMETERY OR CREMATORY Harmony Memorial Park, Landover, Md.
23d. LOCATION (CITY OR TOWN COUNTY STATE)				
24. FUNERAL DIRECTOR Stewart Funeral Home-4001 Benning Rd.		25. DATE REC'D. BY REGISTRAR N. APR 12 1983		26. REGISTRAR'S SIGNATURE John J. Curran

Virginia

USA

Retired

William

Clay

Calico

Mountain

Mr. Thomas B. Clay - 301

87 (1) 200100000, U.S. Washington, D.C.

Mr. Vos

300 COTTON



Initial

April 9, 1983

Library, London, U.K.

Excerpt Thomas B. Clay - 301

Library



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 4 9  
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) <b>PATRICIA NEULAND CLAYTON</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4-23-83</b>		2b. HOUR <b>10 P M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 6 1925</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>58</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4970 Battery Lane</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Director of Volunteers</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>	
13a. STATE <b>Md. 20814</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Fred</b> MIDDLE <b>J.</b> LAST <b>Neuland</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Anne</b> MIDDLE <b>Harvey</b> LAST <b>Harvey</b>		13e. STREET ADDRESS <b>4970 Battery Lane</b>		20814	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-32-6123</b>		17. INFORMANT <b>Timothy C. Clayton</b>		ADDRESS <b>1161 Balfour Grosse Pointe Park, Michigan</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1749 IMMEDIATE CAUSE (a) CARCINOMA OF THE BREAST</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 YRS</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-22-83</b> , to <b>4-23-83</b> , that (I) (we) lost saw the deceased alive on <b>4-22-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Richard H. Pollen</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-24-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD H. POLLEN</b>		22e. ADDRESS <b>10400 Connecticut Av, Kensington, MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/27/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Mary's Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> <b>5130 Wisc. Ave., N.W. Washington, D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 27 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>	

MEDICAL CERTIFICATION





100 Inc. Ave., N. W., Washington, D. C.  
To: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation  
From: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation  
Subject: [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 10850	
1. DECEASED NAME (TYPE OR PRINT) <b>ida L Cockshott</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 / 26 / 83</b>		2b. HOUR <b>5:25 P.M.</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>12 31 21</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>Separated</b>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.		
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1131 Univ. Bldg. W. 1016</b>	
14. FATHER'S NAME FIRST <b>Edward</b> MIDDLE LAST <b>Whitley</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Anita</b> MIDDLE LAST <b>Flagley</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b> (IF YES, GIVE WAR OR DATES) <b>N/A</b>		
16b. SOCIAL SECURITY NO. <b>212-16-4764</b>		17. INFORMANT ADDRESS <b>Edward H. Cockshott-husband 8750 Ga. Ave S.S. Md. 20910</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ventricular Fibrillation</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiogenic Shock</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Massive Anterior Wall Myocardial Infarct</b> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST: <b>4100</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <b>Minutes</b> <b>&gt;24 hours</b> <b>24 hours</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Diabetes Mellitus</b>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/26</b> , 19 <b>83</b> , to <b>4/26</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>4/26</b> , 19 <b>83</b> , and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Herman B Segal MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/26/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Herman B. Segal MD</b>		22e. ADDRESS <b>5632 Shields Drive Beltsville Md 20816</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Cremation</b>	23b. DATE <b>4-29-83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, DC</b>	
24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home</b>		11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>	

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1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the methodology. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is to study the reaction of hydrogen peroxide with potassium iodate in acidic solution. The methodology is to use the method of initial rates.

2. The second part of the report is a description of the experimental procedure. It includes the list of materials, the list of apparatus, and the description of the procedure. The materials are hydrogen peroxide, potassium iodate, sulfuric acid, and sodium metabisulfite. The apparatus are a conical flask, a stopper, a thermometer, and a stopwatch. The procedure is to prepare a series of solutions of different concentrations of hydrogen peroxide and potassium iodate, and to measure the time taken for the reaction to occur.

3. The third part of the report is a description of the results. It includes a table of the data, a graph of the data, and a discussion of the results. The data is as follows:

Temperature (°C)	Time (s)
20	120
30	60
40	30
50	15

The graph shows that the rate of reaction increases with temperature. The activation energy of the reaction is determined to be 50 kJ/mol.

4. The fourth part of the report is a conclusion. It summarizes the findings of the experiment and discusses the implications of the results. The conclusion is that the rate of reaction increases with temperature, and that the activation energy of the reaction is 50 kJ/mol. The implications of the results are that the reaction is exothermic, and that the rate of reaction is controlled by the activation energy.

5. The fifth part of the report is a list of references. It includes the names of the authors, the titles of the papers, and the names of the journals. The references are as follows:

1. Smith, J. D. "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodate." *Journal of Chemical Education*, 1980, 57, 123-125.

2. Jones, A. B. "The Kinetics of the Reaction of Hydrogen Peroxide with Potassium Iodate." *Journal of Physical Chemistry*, 1975, 79, 456-458.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 5 1 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Harry Herbert Cohen</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 1 1983</b>				2b. HOUR <b>9:40 P<sub>M</sub></b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 15 1897</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Phila. Pa.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11539 Cushman Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Public Acct.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>			
13a. STATE <b>---</b>		13b. COUNTY <b>---</b>		13c. CITY OR TOWN <b>Wash., D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>#1118W 20008</b> <b>3003 Van Ness Street, N.W.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Isaac Cohen</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie R. Dennison</b>				ADDRESS <b>11539 Cushman Rd.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Dr. George J. Cohen</b>				ADDRESS <b>Rockville, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>1629 IMMEDIATE CAUSE (a) CARCINOMA OF THE LUNG</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 MONS.</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from <b>19 72</b> , to <b>MAR 1</b> , 19 <b>83</b> , that (1) we) lost saw the deceased alive on <b>FEB 27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) we) (1) did not) view the body after death.											
22b. SIGNATURE <b>Robert S. Poole</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>2 MAR 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT S. POOLE</b>				22e. ADDRESS <b>4501 CONN. AVE. N.W. D.C. 20008</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>3/3/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi Maryland</b>		23e. DATE REC'D. BY REGISTRAR <b>MAR 7 1983</b>			
24. FUNERAL DIRECTOR <b>Warner E. Pumphrey, Inc.</b>				P.O. Box 7428 ADDRESS <b>Sil. Spr., Md.</b>		25. REGISTRAR'S SIGNATURE <b>John J. Conish</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please return carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified directly.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 5 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>NETTIE Cohen</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 25, 1983</b>		2b. HOUR <b>11:07 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 30, 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (UNASCERTAINABLE)		15. MOTHER'S MAIDEN NAME (UNASCERTAINABLE)		13e. STREET ADDRESS <b>6121 MONTROSE ROAD 20852</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> NO OR UNKNOWN <input type="checkbox"/> (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>579-48-1756</b>		17. INFORMANT <b>ROSE C. KRAMER, SILVER SPRING, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cancer of the Bladder</b> <b>1889</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>12-26, 1979</b> to <b>4/24, 1983</b> , that (I) (we) last saw the deceased alive on <b>4/25, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>R. Shakir</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/25/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAMLETH T.A. SHAKIR</b>				22e. ADDRESS <b>6121, MONTROSE RD Rockville MD 20852</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>4/26/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT LEBANON CEMETERY</b>		23d. LOCATION <b>ADELPHI PRINCE GEORGE'S</b>	
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>				25. DATE REC'D BY REGISTRAR <b>APR 28 1983</b> REGISTRAR <b>John S. Maryland</b>			

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CHERRY VAM





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 5 3

1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Gladys E. Coleman</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>April 18, 1983</i>		2b. HOUR <i>0750 A M</i>
3. SEX <i>Female</i>	4. RACE <i>Caucasian</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>May 4, 1903</i>		6. AGE (IN YEARS (LAST BIRTHDAY)) <i>79</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i>	
10. CITY OR TOWN OF DEATH <i>Rockville</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hosp.</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>	12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. STATE <i>Maryland</i>			13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Rockville</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Ferdinand Somerville Auterback</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Clara Gott Ganley</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-36-4323</i>		17. INFORMANT ADDRESS <i>Thomas B. Coleman, same as #13</i>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Anoxic Encephalopathy</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 mo.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular Accident</i>	<i>4 mo.</i>
	DUE TO, OR AS A CONSEQUENCE OF (c) <i>CNS Hemorrhage</i>	<i>4 mo.</i>

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

*Decubitus Ulcer of Left Foot*

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec.</i> , 19 <i>82</i> , to <i>April 18</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>April 17</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Frank J. Mayo, MD</i>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>4-18-83</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Frank J. Mayo</i>	22e. ADDRESS <i>16220 Frederick Rd., Gaithersburg, Md. 20878</i>		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>April 21, 1983</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Darnestown Presby. Church Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Darnestown, Maryland</i>
24. FUNERAL DIRECTOR NAME <i>Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland 20850</i>		25. DATE REC'D. BY REGISTRAR <i>APR 26 1983</i> REGISTRAR'S SIGNATURE <i>John J. Coughlin</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

MADE IN U.S.A.



APR 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

1 0 8 5 4

REG. NO.

DECEASED NAME (TYPE OR PRINT) <b>MARGARET M. COMERFORD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-6-83</b>		2b. HOUR <b>9:35 AM</b>	
1. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 2, 1887</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>95</b> YRS.		
10. CITY OR TOWN OF DEATH <b>Gaithersburg</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WILSON HEALTH CARE CENTER</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD</b>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Matron</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>New York Court</b>				
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Monahan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Purtell</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>096-32-4696</b>		17. INFORMANT <b>Agnes Cellotta, 18319 Lost Knife Circle, Gaithersburg, MD 20877</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Generalized arteriosclerosis</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hr.</b> <b>Sym.</b> <b>Sym.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Hip fracture, Anemia 2nd to hip fracture</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 16, 1981</b> to <b>April 6, 1983</b> , that (I) (we) lost <b>above</b> the deceased alive on <b>April 1, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.						
22b. SIGNATURE <b>James R. Moore Jr.</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4-6-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James R. Moore Jr.</b>		22e. ADDRESS <b>207 Brookes Ave Gaithersburg</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 9, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Calvary Cemetery</b>		
24. FUNERAL DIRECTOR NAME <b>Conway Funeral Home</b>		24b. LOCATION CITY OR TOWN COUNTY STATE <b>Queens County, New York</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 11 1983</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of it.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) <b>Naomi Evans Comerford</b>									
2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR <b>P<sub>M</sub></b>	
April 22, 1983								1:00 <b>P<sub>M</sub></b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 12, 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5707 Ridgefield Road</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>5707 Ridgefield Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Alfred D. Evans</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Catherine Landis</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					
16b. SOCIAL SECURITY NO. <b>579-60-4347</b>		17. INFORMANT (Sister) ADDRESS <b>Ida Coffey 5707 Ridgefield Rd Bethesda, Maryland</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>1539</b> IMMEDIATE CAUSE (a) <b>cardiorespiratory failure</b> 2 hrs DUE TO, OR AS A CONSEQUENCE OF (b) <b>metastatic carcinoma of colon</b> 6 months DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb 1980</b> , to <b>present</b> , 19 <b>80</b> , that (I) (we) last saw the deceased alive on <b>Feb 1980</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									
22b. SIGNATURE <b>John O. Allin</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John O. Allin M.D.</b>		22e. ADDRESS <b>8218 Wisconsin Ave Bethesda</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 25, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Neffsville Bretheran</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Lancaster Pennsylvania</b>		23e. DATE REC'D BY REGISTRAR <b>APR 26 1983</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>		24b. ADDRESS <b>Homes P A Bethesda Maryland</b>		25a. DATE REC'D BY REGISTRAR <b>APR 26 1983</b>					
25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>									





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

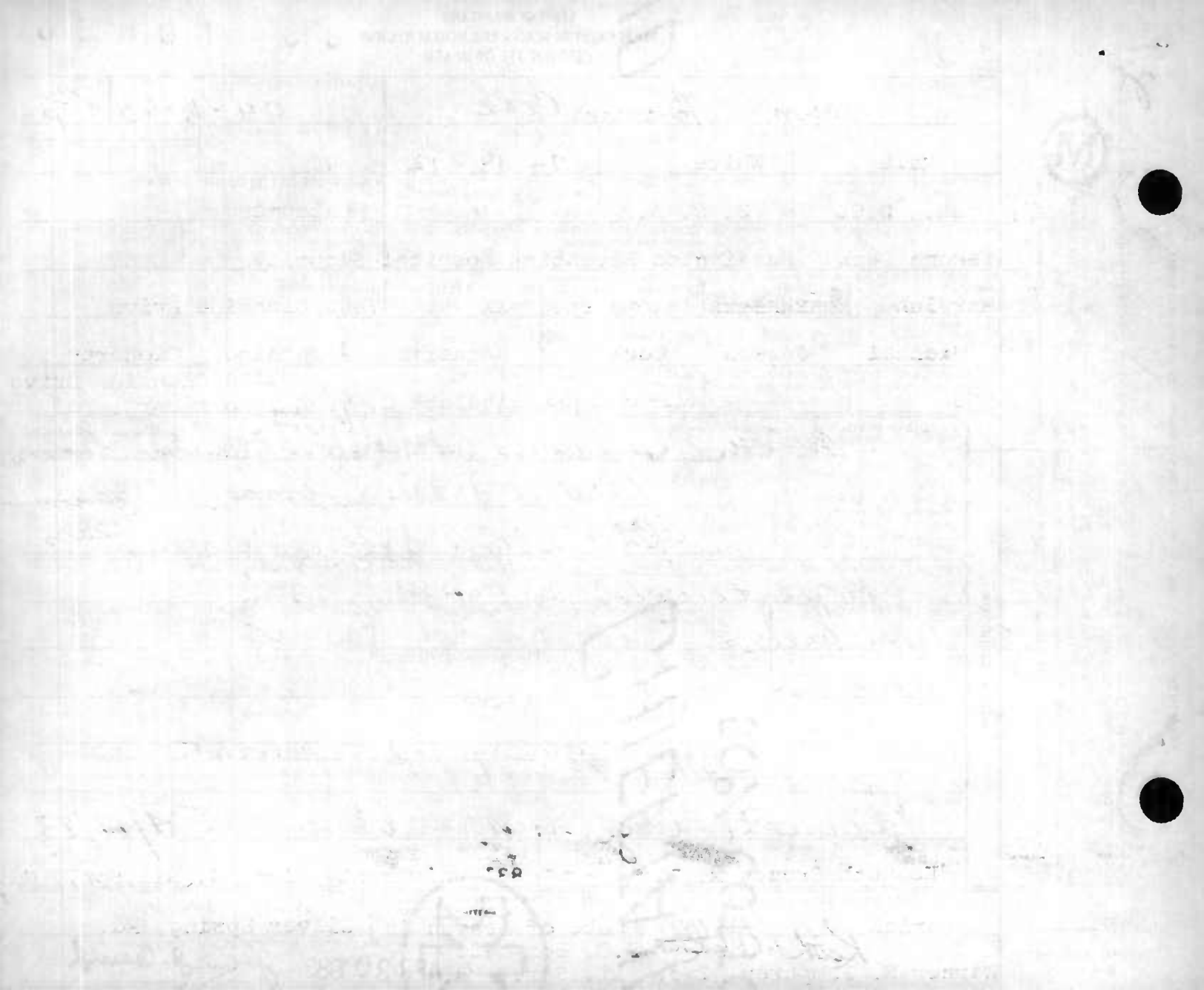
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 8 5 6			
1 - FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>John Bernard Cook</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>04-16-83</i>		2b. HOUR <i>7:00 P.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>7-19-12</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>70</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash., D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.	
10. CITY OR TOWN OF DEATH <i>Takoma Park</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Washington Adventist Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Security</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Bank</i>	
13a. STATE <i>Maryland</i>		13b. CITY OR TOWN <i>Takoma Pk.</i>		13c. STREET ADDRESS <i>7400 Glenside Drive</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Michael Joseph Cook</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Katherine Josephine Cloherty</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>215-44-7855</i>	
17. INFORMANT ADDRESS <i>7400 Glenside Drive</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Massive intracerebral hemorrhage</i>		19. DATE OF OPERATION <i>None recent</i>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>4/16/83</i>		21a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Home</i>		21b. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>January 1982</i> to <i>present</i> 19 <i>83</i> , that (I) (we) lost the deceased alive on <i>4/16/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <i>Kenneth Cruze</i> DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>4/17/83</i>		22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Kenneth Cruze, M. D.</i>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4/19/83</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Gate of Heaven Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Silver Spring, Md.</i>	
24. FUNERAL DIRECTOR <i>Warner E. Pumphrey, Inc.</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 20 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Gough</i>		25c. P.O. Box 7428	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 3 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

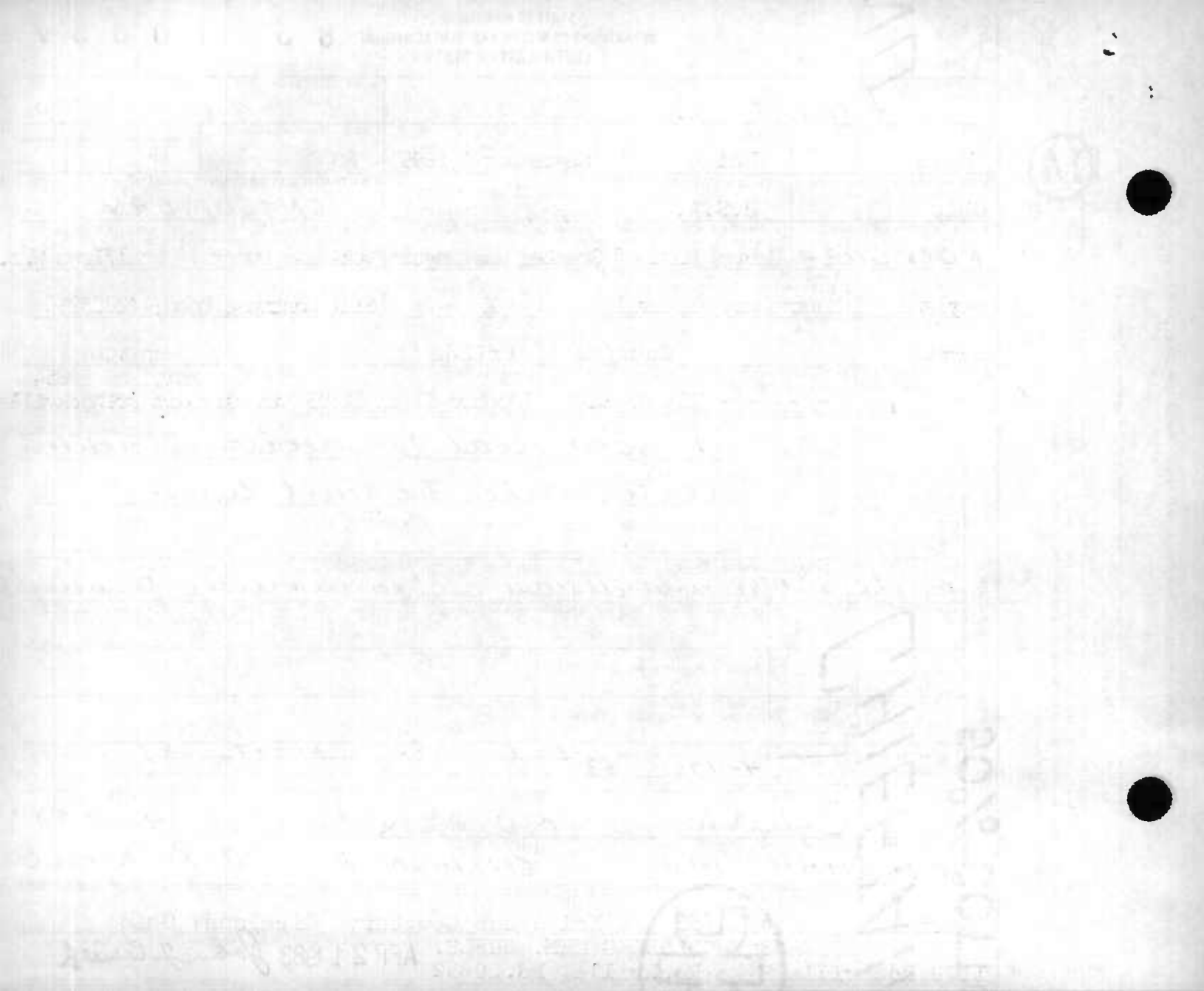
1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 5 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Albert E. COUSINS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-17-83</b>			2b. HOUR - MIN <b>8:05 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>September 4, 1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Washington</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Business Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Metal/Iron Wks.</b>	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Samuel Cousins</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Frieda Bernstein</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>276-07-2219</b>			17. INFORMANT ADDRESS <b>Leonard Sloan; 12605 Lincolnshire Dr; Rockville Maryland 20854</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Peripheral vascular disease, ischemic ulcers, Alzheimer's disease</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) <del>this hospital</del> attended the deceased from <b>4-17-83</b> to <b>4-17-83</b> , that <del>he</del> (we) lost saw the deceased alive on <b>4-17-83</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>we</del> did not view the body after death.									
22b. SIGNATURE <b>R. Shah</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-18-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K.H. SHAH MD</b>			22e. ADDRESS <b>6121 MONTROSE RD. ROCKVILLE</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4/20/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>B'Nai Jacob Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Richland; Ohio</b>		
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEM. CHPLS.</b>						25. DATE REC'D. BY REGISTRAR (BY REGISTRAR'S SIGNATURE) <b>APR 21 1983</b>			
1170 Rockville Pike; Rockville, Md. 20852									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 5 8

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>GRACE CRAFT</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4-22-83</b>		2b. HOUR <b>10 A.M.</b>	
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>February 13, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Rockville MD</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebron Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY -----
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Rockville</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>6121 Montrose Road (20852)</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard Rehfeld</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Jennie Abrams</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>117-36-8313</b>		17. INFORMANT ADDRESS <b>Joy Craft; 214 East 51st; New York, N.Y.</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>5070 IMMEDIATE CAUSE (a) Pneumonia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7/5/83</b>	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Aspiration</b>		4-22-83	
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 11 - 1982</b> to <b>4/22/83</b> , that (I) (we) lost saw the deceased alive on <b>4/21/83</b> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>R. Shakin</b>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>4/22/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RAMLETH T.A. SHAKIN</b>		22e. ADDRESS <b>6121 Montrose Rd Rockville MD 20852</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>April 24, 83</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Hebron Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Flushing; Queen's County; N.Y.</b>
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEMORIAL CHAPEL</b>		24b. DATE REC'D. BY REGISTRAR <b>APR 25 1983</b>	
1170 Rockville Pike; Rockville, Maryland 20852		REGISTRAR'S SIGNATURE <b>John G. Canine</b>	



DEFINITION

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 5 9

FOR  
1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Helen S. Crehan			2a. DATE OF DEATH MONTH DAY YEAR 4 29 1983			2b. HOUR 4:00 a.m.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 25 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1618 Muriel Street Rockville				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 199 Rollins Avenue 20852	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Shea				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Johanna Casey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 089-20-9999		17. INFORMANT ADDRESS Ann Fitzgerald 618 Muriel St. Rockville, Md. 20852			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>&lt; 1 minute</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Myocardial infarction. Chronic heart failure</u>									
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOT BY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 21</u> 19 <u>83</u> , to <u>April 24</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>April 24</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Augustus A. Aquino</u>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/29/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Augustus A. Aquino						22e. ADDRESS 20014 10401 Old Georgetown Rd. Bethesda, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/2/83		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery			23d. LOCATION CITY COUNTY Silver Spring, Maryland	
24. FUNERAL DIRECTOR NAME Eysen Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Md. 20852						25a. DATE REC'D. BY REGISTRAR MAY 6 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



These are the only information I have found  
in the records of the Bureau of  
Prisons and Penitentiaries  
at the State of New York  
for the year 1900.

Wm. J. R. [illegible]

FILED  
11/11/11



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 8 6 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Mary Ellen Cummings				MONTH DAY YEAR April 30 1983			
3. SEX				2b. HOUR			
Female				8 a. M.			
4. RACE				6. AGE (IN YEARS LAST BIRTHDAY)			
White				68 YRS.			
5. DATE OF BIRTH				IF UNDER 1 YEAR			
MONTH DAY YEAR May 9 1914				MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				9. BALTIMORE CITY OR COUNTY OF DEATH			
Md.				Montgomery MD.			
7b. CITIZEN OF WHAT COUNTRY?				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
U.S.A.				Housewife			
10. CITY OR TOWN OF DEATH				12b. KIND OF BUSINESS OR INDUSTRY			
Gaithersburg				-			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				13a. STREET ADDRESS			
21041 Brink Ct.				21041 Brink Court (20879)			
13b. COUNTY				13c. CITY OR TOWN			
Montgomery				Gaithersburg			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST James Williams Cummings				FIRST MIDDLE LAST Mary Elizabeth Green			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
No				577-14-7639			
17. INFORMANT				ADDRESS			
Bernard A. Cummings				21041 Brink Ct. Gaithersburg, Md. 20879			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>cardiac arrest</i>				10 mth.			
4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arterio-sclerotic heart disease</i>				5 yrs			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				DUE TO, OR AS A CONSEQUENCE OF (c) <i>chronic obstructive pulmonary disease</i>			
				15 yrs			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>							
21f. LOCATION				CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 29 Apr</i> 19 <i>83</i> , to <i>30 Apr</i> 19 <i>83</i> , that (I) (we) lost saw the deceased <i>die</i> on <i>29 Apr</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
<i>John M. Wyman</i>				5/2/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
John M. Wyman, M.D.				7801 Norfolk Ave., Bethesda, Md. 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				5/3/83			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Mount Olivet Cemetery				Washington, D.C.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR			
<i>Gartner Sandison F. H.</i>				MAY 3 1983			
316 E. Diamond Ave., Gaithersburg, Md. 20877				25b. REGISTRAR'S SIGNATURE			
				<i>John J. Gartner</i>			

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• *Library*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 8 6 1	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>JENNIE MARCH CUNARD</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 28 1983</b>		2b. HOUR <b>4:48 a.m.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 20 1924</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE <b>VIRGINIA</b>		13b. COUNTY <b>FAIRFAX</b>	13c. CITY OR TOWN <b>ALEXANDRIA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>STEPHEN JOHN MARCH</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>JULIA M. MELLON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>564-44-4882</b>		17. INFORMANT ADDRESS <b>EARL M. CUNARD, JR., 6205 LARSTAN DRIVE,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC ADENOCARCINOMA</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 23</b> , 19 <b>83</b> , to <b>MARCH 28</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>MARCH 28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
23a. SIGNATURE <b>LEE E. ARTMAN, CDR, MC, USN</b>		DEGREE		23b. DATE SIGNED <b>3/29/83</b>	
24. FUNERAL DIRECTOR NAME <b>D. Michael Seron</b>		ADDRESS <b>Falls Church, VA</b>		25. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>29 Mar 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lees Crematory</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>		23e. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR NAME <b>D. Michael Seron</b>		ADDRESS <b>Falls Church, VA</b>		25. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>	



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified along with the attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 8 6 2	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>EMMETT BOWE DAVENPORT</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 4 83</b>		2b. HOUR <b>950 A.M.</b>							
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 12, 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co. MD.</b>					
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>BROOKE GROVE NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Pattern Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy Ships</b>					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md. 20817</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8012 Beech Tree Rd.</b>			
FATHER'S NAME FIRST MIDDLE LAST <b>Unknown - Davenport</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Nana - King</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <b>Unk.</b>		16b. SOCIAL SECURITY NO. <b>577-01-5505</b>		17. INFORMANT <b>Elaine D. Stoner</b>		ADDRESS <b>Same as # 13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest.</b> <b>4439</b> DUE TO, OR AS CONSEQUENCE OF (b) <b>Sepsis 2° to gangrene lower leg</b> DUE TO, OR AS CONSEQUENCE OF (c) <b>Pulmonary vascular disease.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Generalized arteriosclerosis</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>4/1 83</b> 19 <b>82</b> , to <b>4/4/83</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>4/1/83</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated											
22b. SIGNATURE <b>Ruben Cosca</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4-4-83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RUBEN COSCA, M.D.</b>		22e. ADDRESS <b>17529 REDLAND ROAD DETLWOOD, MARYLAND, 20855</b>									
23a. BURIAL, CREMATION, REMOVAL SPECIES <b>CREMATION</b>		23b. DATE <b>Apr. 5, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>					
24. FUNERAL DIRECTOR NAME <b>FRANCIS H. BARBER</b>		ADDRESS <b>LAYTONSVILLE, MD. 20879</b>		25a. DATE RECEIVED BY REGISTRAR <b>APR 7 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>					

BP

100

8

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE

JAN 10 1967

TO : DIRECTOR, FBI  
FROM : SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

Enclosed for the Bureau are two copies of a letterhead memorandum (LHM) dated and captioned as above. The LHM was prepared by the New York Office on January 9, 1967.

Very truly yours,  
[Signature]

2/1/67  
[Circular Stamp: RECEIVED, JAN 10 1967, FBI NEW YORK]  
[Text: NEW YORK OFFICE, JAN 10 1967]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 6 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR a M	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANN ROGERS DAVIDSON		APRIL 5 1983		11:55 a M	
3. SEX FEMALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR FEBRUARY 20 1915	6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.		
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOME MAKER	12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MARYLAND		13b. COUNTY ANNE ARUNDEL	13c. CITY OR TOWN ANNAPOLIS	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 231 ANCHORAGE CIRCLE 21401
14. FATHER'S NAME FIRST MIDDLE LAST REUBEN DORSEY ROGERS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELEANOR POLK OWINGS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 565-68-1208	17. INFORMANT ADDRESS JOHN F. DAVIDSON, 231 ANCHORAGE CIRCLE, 21401 Annapolis MD		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ADENOCARCINOMA OF THE PANCREAS 1599 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MARCH 25 1983, to APRIL 5 1983, that (I) (we) last saw the deceased alive on APRIL 5 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE R. K. FERGUSON		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 6 APR 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) R. K. FERGUSON, LT, MC, USNR		22e. ADDRESS NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Apr. 8, 1983	23c. NAME OF CEMETERY OR CREMATORY U.S. Naval Academy		23d. LOCATION CITY OR TOWN COUNTY STATE Annapolis A.A. MD	
24. FUNERAL DIRECTOR NAME Taylor Funeral Chapel-Annapolis, MD		25a. DATE REC'D. BY REGISTRAR APR 11 1983		25b. REGISTRAR'S SIGNATURE John J. Lauer	

MEDICAL CERTIFICATION



10-11-12

10-11-12

10-11-12

10-11-12

10-11-12

10-11-12

BH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 6 4

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) DONNA MAE DAVIS			2a. DATE OF DEATH MONTH DAY YEAR APRIL 7, 1983			2b. HOUR 9:35 P M			
3 SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JULY 22, 1959		6. AGE (IN YEARS LAST BIRTHDAY) 23 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY COUNTY MD.			
10. CITY OR TOWN OF DEATH BETHESDA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE CLINICAL CENTER, NIH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier		12b. KIND OF BUSINESS OR INDUSTRY Fast Food	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY Wic		13c. CITY OR TOWN PITTSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS BOX 378, MORRIS RD (21850)	
14. FATHER'S NAME FIRST MIDDLE LAST Norman Duane Kempke			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley Mae Elliott			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 216-70-1419			17. INFORMANT (FATHER) Mr. Norman D. Kempke ADDRESS Rt. #1, Morris Rd. Box 378, Pittssville Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEMOPERICARDIUM AND PERICARDITIS 2019 DUE TO, OR AS A CONSEQUENCE OF (b) EXTENSIVE INTRA PULMONARY HODGKIN'S Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PULMONARY HEMORRHAGE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a HODGKIN'S DISEASE									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MARCH 25, 19 83 to APRIL 7, 19 83, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on APRIL 7, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE D. Kawman ms			DEGREE			22c. DATE SIGNED 4/8/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. Kawman			22e. ADDRESS NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-11-1983		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Mem. Gardens Salisbury Wic. Md.		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Holloway Funeral Home P.A. Salisbury, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR APR 13 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP



BP \_\_\_\_\_  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				8 3 1 0 8 6 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Madelaine Pearl Davis				2a. DATE KNOWN OF DEATH ESTIMATED 4/18 19 83		2b. HOUR 7:47 P.	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Oct. 4, 1907	6. AGE (IN YEARS) LAST BIRTHDAY 75 YRS.	7. UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 4/18 19 83		2d. HOUR P.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Maryland				13b. COUNTY Prince Georges	13c. CITY OR TOWN Kentland	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Coles				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula B. Matthews			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Kentland, Md. 20785 Orin M. Davis-husband 7008 East Forest Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8179 IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) fracture of left hip. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 wks.							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Fracture of left hip.							
19a. DATE OF OPERATION 4/15/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? Fracture of left hip.				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 4 P.M. 3-9 83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Getting out of automobile.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE East Forest Road, Prince Georges, Kentland, Md			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE [Signature]		TITLE (SPECIFY) Deputy		MEDICAL EXAMINER 1919 Seminary Road Silver Spring, Montgomery, Md.		DATE SIGNED 4/20/83	
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers, M.D.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4-20-83		23c. NAME OF CEMETERY OR CREMATORY Lee's Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C. 20002	
24. FUNERAL DIRECTOR NAME ADDRESS Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002				25a. DATE REC'D. BY REGISTRAR APR 25 1983			
				25b. REGISTRAR'S SIGNATURE John J. Canfield			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 8 6 6					
1. FOR STATE REGISTRAR		REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	a	
JOHN DERMAN								APRIL 26 1983					12:30	M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
MALE		CAUCASIAN		DECEMBER 17 1913		69		YRS.		MONTHS		DAYS		HOURS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
NEW YORK		UNITED STATES				MONTGOMERY MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
BETHESDA		NAVAL HOSPITAL				RETIRED		U. S. ARMY							
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
VIRGINIA		FAIRFAX		ALEXANDRIA		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		8575 RICHMOND HIGHWAY 99999							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST					
UNKNOWN		LEWANOVICH				ROSE		UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
YES		1946-1968		477-03-6178		PEARL M. DERMAN, 8575 RICHMOND HIGHWAY,									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) SMALL CELL CARCINOMA															
1991															
DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															
DUE TO, OR AS A CONSEQUENCE OF															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from		MARCH 10, 19 83				to		APRIL 26, 19 83		that (I) (we) lost					
saw the deceased alive on		APRIL 26, 19 83				and that in (my) (our) opinion death occurred on the date and hour and from the causes stated		above (I) (we) (did) (did not) view the body after death.							
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. DATE SIGNED				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
MARION R. McMILLAN, LT, MC, USNR		22e. ADDRESS				NAVAL HOSPITAL, NAVAL MEDICAL COMMAND,		NATIONAL CAPITAL REGION, BETHESDA, MD 20814							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN									
Burial		4-29-83		Mt. Comfort Cemetery		Alexandria, Va.									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR				REGISTRAR'S SIGNATURE									
Everly-Wheatley Alexandria, Va.		MAY 2 1983				John J. Canfield									





74. FUNERAL DIRECTOR NAME 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901	FRANCIS J. COLLINS ADDRESS	75a. DATE REC'D. BY REGISTRAR MAY 2 1983	REGISTRAR'S SIGNATURE <i>John J. Smith</i>
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DHMH - 16 50M 4/82  
(VRA 15. 4)



*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph document, possibly a letter or a report, written in a cursive or semi-cursive hand. The text is mirrored across the page, suggesting it may be bleed-through from the reverse side.]*

*[Faint, illegible text lines covering the majority of the page.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 6 8

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charles J. Diller</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-29-83</b>			2b. HOUR MIN. <b>12:40 A</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>April 25 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Brooke-Grove Foundation</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Patent Attorney</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Pvt. Law Firm</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4004 Montpelier Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Diller</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(Unknown) (Unknown)</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>216-38-5790 A</b>		17. INFORMANT ADDRESS <b>Md. 3507 Dunlop St Chevy Chase</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO-RESPIRATORY ARREST</b> <b>2030</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MULTIPLE MYELOMA</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5+ years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>ALZHEIMER'S DISEASE</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>AUGUST 19 81</b> to <b>APRIL 29 83</b> , that (I) (we) lost saw the deceased alive on <b>4-25-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Ra fael A Matheus MD</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-29-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Ra fael A Matheus, M.D.</b>					22e. ADDRESS <b>13018 Georgia Ave., Wheaton, Md. 20906</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>5/2/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>George Washington Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Adelphi Maryland.</b>		
24. FUNERAL DIRECTOR NAME ADDRESS <b>Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Washington, D.C.</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>		

25

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 8 6 9	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Esther</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>4-29-83</b>					2b. HOUR <b>12:35 PM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 15, 1887</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>96</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS.</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>RUSSIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
13a. STATE <b>MARYLAND</b>					13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>ROCKVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>ISAAC DOSIK</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE (UNASCERTAINABLE) <b>ANNA</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? NO (NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. <b>577-64-9874</b>		17. INFORMANT <b>STANLEY DOSIK,</b>		17. ADDRESS <b>9579 EVERGREEN STREET SILVER SPRING, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs</b> <b>2 hrs</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION <b>4/29</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>4/29</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/29 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>4/29 1983</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.) <b>4/29</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>4/29 1983</b>							
22a. I certify that (1) this hospital attended the deceased from <b>4/29 1983</b> to <b>4/29 1983</b> , that (b) we last saw the deceased alive on <b>4/29 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (all) did not view the body after death.											
22b. SIGNATURE <b>R. Bass</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-29-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. BASS</b>				22e. ADDRESS <b>3929 FENELLA DR WILMINGTON 20906</b>							
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>5/1/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT LEBANON CEMETERY</b>		23d. LOCATION <b>ADELPHI, PRINCE GEORGE'S, MARYLAND</b>					
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>			
232 CARROLL STREET, N.W., WASHINGTON, D. C.											



MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 7 0	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Joseph Louis Dubin</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 8, 1983</b>		2b. HOUR <b>2:10 A.M.</b>
3. SEX <b>male</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 30 1902</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80 YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital Forest Glen</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FOOD</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>FOOD BROKER</b>
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>Montgomery</b>	13c. CITY OR TOWN <b>Silver Spring</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1900 Lyttonsville Rd.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>BARNETT DUBIN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(UNASCERTAINABLE) (UNASCERTAINABLE)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>075-18-9544A</b>		17. INFORMANT ADDRESS <b>BLANCHE SONIA DUBIN, 1900 LYTTONSVILLE ROAD SILVER SPRING, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Brain Death</b> <b>3481</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>4x90mm. Bilateral chronic subdural</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>two</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min.</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/17 1983</b> to <b>4/17 1983</b> , that (I) (we) last saw the deceased alive on <b>4/17 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E. H. Levin</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4/17/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EDGAR H. LEVIN, M.D.</b>		22e. ADDRESS <b>8630 FENTON STREET SILVER SPRING, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>4/10/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>KING DAVID MEMORIAL GARDEN</b>	
23d. LOCATION <b>FALLS CHURCH, VIRGINIA</b>					
24. FUNERAL HOME OR PLACE OF INTERMENT <b>DAVID M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 12 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Lewis</b>	
24. ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 10871			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Mark Christopher Duchesne</b>				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <b>Apr. 20, 83 11:00 P.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 12, 1964</b>		6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New Jersey</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Student</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>College</b>	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Maryland Montgomery Rockville</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS (20852) <b>11301 Commonwealth Drive</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edmund F. Duchesne</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosemary Welch</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>				16b. SOCIAL SECURITY NO. <b>215-94-6712</b>		17. INFORMANT ADDRESS <b>Edmund F. Duchesne PO Box 555 West End, NC</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Oligoblastoma, brain</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2-3 days</b> <b>3 months</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 22</b> , 19 <b>83</b> , to <b>Apr 20</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Apr 20</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John W Barrett</b> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Apr. 21, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John W Barrett</b>				22e. ADDRESS <b>3 Washington Circle, 306, Wash. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 25, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>				24b. ADDRESS <b>Homes, P.A. Bethesda, Maryland 20814</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 26 1983</b>	
				25b. REGISTRAR'S SIGNATURE <b>John J. Cunniff</b>			

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IMPORTANT: If item 21 is marked or item 48 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 7 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>ALBERT F. DUGGAN</b>				2r. DATE OF DEATH MONTH DAY YEAR <b>APRIL 26 1983</b>		2b. HOUR <b>6 15 A/M</b>	
3 SEX <b>Male</b>		4 RACE <b>Caucasian</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>December 18, 1893</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>89</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>North Dakota</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD</b>	
10 CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				Zip Code: <b>20815</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frederick Duggan</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary Ann O'Reilly</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>216-44-2916</b>		17 INFORMANT (Nephew) <b>Dennis Duggan</b>		ADDRESS <b>9939 Julliard Dr. Bethesda, Maryland 20817</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>acute Heart Infarction</b>				<b>1 hour</b>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				(b) <b>Generalized Arteriosclerosis Semic</b>			
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 80</b> to <b>April 26 19 83</b> , that (we) last saw the deceased alive on <b>4-26-83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>P.P. Andrews M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4-26-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>P.P. ANDREWS</b>				22e. ADDRESS <b>4977 BATTERY LANE BETHESDA MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 29, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Columbia Gardens Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>	
24 FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	
Homes, P.A., Bethesda, Maryland							

BP



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR THE DIVISION OF VITAL RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DIVISION OF VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Robert A. Duley</b>						2a. DATE KNOWN OF DEATH ESTIMATED <b>April 13, 1983</b>					
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>May 18, 1925</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>April 30, 1983</b>	2b. DATE KNOWN OF DEATH ESTIMATED <b>April 30, 1983</b>				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>					
10. CITY OR TOWN OF DEATH <b>Pilgrimage Holy Cross Hosp.</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Printer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Govt.</b>			
13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>MD Prince Georges Adelphi</b>		13c. CITY OR TOWN <b>Delphi</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>10906 Ashley Rd</b>		20783			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Arthur A. Duley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Irene E. Downing</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT <b>Christina M. Duley-wife-(same as 13e)</b>		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4291 IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
<b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>M.D.</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, DME</b>				ADDRESS <b>1905 Seminary Rd., Silver Spring, Md.</b>				DATE SIGNED <b>April 30, 1983</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-4-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood Pr. Georges Md.</b>					
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>					

BP

15th



*[Faint, mostly illegible handwritten text covering the majority of the page. Some words like "received" and "paid" are faintly visible.]*

received of [illegible] 100





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 8 7 4	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>Alonzo Franklin Dunlap</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>April 9, 1983</b>			2b. HOUR MIN. <b>5:50 A</b>		
3 SEX <b>Male</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 29, 1967</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>15</b>		7. IF UNDER 1 YEAR HOURS MIN. <b>15</b>		7b. IF UNDER 24 HRS HOURS MIN. <b>15</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>DC Washington</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD					
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH Clinical Center, Bethesda, Md.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>D.C.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3042 Stanton Rd., S.E.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Jones</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Abby Dunlap</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT ADDRESS <b>Mrs. Abby Dunlap, Mother, same as patient</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Marked pneumonitis and pulmonary fibrosis</b> 2791 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Wiskott-Aldrich Syndrome</b> 15 years DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 3, 1983</b> to <b>April 9, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 9, 1983</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.											
22b. SIGNATURE <b>Frederick P. Ogribene, MD</b>				DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/9/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Frederick P. Ogribene, M.D.</b>				22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, Md. 20205</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-14-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Mem Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover PG Md</b>			
24. FUNERAL DIRECTOR NAME <b>Marshall's Funeral Home</b> <b>4217 9th Street NW, Washington, D.C.</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 18 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			



20% COTTON  
CHILF



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 7 5

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Bernard Leonard Eberts			2a. DATE OF DEATH MONTH DAY YEAR April 20, 1983			2b. HOUR 7:30 P.M.				
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 21, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.				
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4613 Morgan Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY Insurance		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4613 Morgan Drive Zip: 20815	
14. FATHER'S NAME FIRST MIDDLE LAST Christian Eberts			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Leonard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			16b. SOCIAL SECURITY NO. 579-12-6974		17. INFORMANT Jeanine E. Stanek, daughter ADDRESS 813 Allison Way Sunnyvale, California					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1/2 hr 2 hr		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Uremia</u>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (my) (myself) attended the deceased from <u>April 18, 1983</u> to <u>April 20, 1983</u> , that (I) (we) lost <u>the deceased</u> on <u>April 20, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Joseph Wallace</u> MD					DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph Wallace MD					22e. ADDRESS 5272 River Road, Bethesda, Maryland 20816					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE April 23, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A., Bethesda, Maryland					25a. DATE REC'D. BY REGISTRAR APR 26 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

RECEIVED

CHECK

100%



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 806

DHMH-16 50M/181  
(VRA 15, 4)

#6, Film G578 4/28/83 kam		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 3 1 0 8 7 6	
1. FOR REGISTRATION Item 18c Film 579 5-5-83				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MORRIS ECKSTEIN</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>04-12-83</b>		2b. HOUR <b>8:15 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 1, 1916</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>67-66</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Czechoslovakia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>804 Orchard Way</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Restaurant Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Food</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>				13b. CITY OR TOWN <b>Silver Spring</b>		13c. STREET ADDRESS <b>804 Orchard Way (20904)</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Aaron Eckstein</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lea Feldman</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>053-24-7426</b>		17. INFORMANT ADDRESS <b>Maryland 20904</b> <b>Serena Eckstein; 804 Orchard Way; Silver Spring</b>					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Pulmonary tuberculosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Myelofibrosis Hypoglycemia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 hrs.</b> <b>8 yrs.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN IDENTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>November 20, 1975</b> to <b>April 12, 1983</b> , that (I) (we) last saw the deceased alive on <b>April 4, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>S. S. ...</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/12/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Edward S. Levin M.D.</b>		22e. ADDRESS <b>8630 Fenton Rd. #230 Silver Spring, Md. 20910</b>					
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>April 13, 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beth Israel Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodbridge; Middlesex; N.J.</b>	
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEMORIAL CHAPELS</b>				25a. DATE RECD. BY REGISTRAR <b>'APR 15 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. ...</b>	
1170 Rockville Pike; Rockville, Md. 20852							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 7 7 REG. NO.					
I. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
KARL E. ELLERMANN								4/30/83				2 10 P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		7-18-98		84 YRS.		MONTHS		DAYS			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
OHIO		USA				MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
SILVER SPRING		Holy Cross Hospital				Retail Research							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		14. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Montg.		Gaithersburg		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		201-Russell Ave. 20877			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST				FIRST MIDDLE LAST									
Frederick Ellermann				Name Freistoe									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
yes				577-24-1405		Noble May Ellermann		13e.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> <u>5109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Emphysema</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
4/1/83				Emphysema				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				P.M. 19									
21d. INJURY OCCURRED				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						STREET							
22a. I certify that (1) (this hospital) attended the deceased from <u>4/14</u> , 19 <u>83</u> , to <u>4/30</u> , 19 <u>83</u> , that (1) (we) lost saw the deceased alive on <u>4/29</u> , 19 <u>83</u> , and that in (m) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.													
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
[Signature]										4/30/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
Jay Weiner MD				4701 Randolph Rd Rockville, Md									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN COUNTY STATE)							
Cremation		May 2-1983		St. Louis Cemetery		Baltimore, Md.							
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Takoma Funeral Home.				MAY 3 1983				[Signature]					
54 Carroll St. N. W. D.													

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gey

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

1 0 8 7 8

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES RICHARD ENGLAND</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 24, 1983</b>		2b. HOUR <b>10:20p M</b>	
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 16, 1952</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>31</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Michigan</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>		
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CLINICAL CENTER, NIH, BETHESDA, MD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>None</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. STATE <b>NORTH CAROLINA</b>		13b. CITY OR TOWN <b>CHARLOTTE</b>	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>7001 QUEENSBERRY DRIVE-28211</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Richard England</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Malvina LaMarre</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>366 54 5334</b>		17. INFORMANT ADDRESS <b>CHARLES R. ENGLAND, FATHER SAME AS PATIENT</b>		
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory insufficiency, secondary to pulmonary hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Widely metastatic testicular germ cell tumor</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Deep vein thrombosis, bilateral</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1869 days</b> <b>weeks</b> <b>days</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>						
19a. DATE OF OPERATION <b>April 19, 1983</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Metastatic testicular carcinoma</b>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>APRIL 14, 1983</b> to <b>APRIL 24, 1983</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>APRIL 24, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death.						
22b. SIGNATURE <b>Joseph A. Kovacs</b>		DEGREE <b>Attending Physician</b>		22c. DATE SIGNED <b>4/25/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph A. Kovacs</b>		22e. ADDRESS <b>NATIONAL INSTITUTES OF HEALTH, CLINICAL CENTER, BETHESDA, MD 20205</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>April 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carolina Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Concord North Carolina</b>
24. FUNERAL DIRECTOR - NAME <b>Robert A. Pumphrey</b>				25. DATE REC'D BY REGISTRAR <b>MAY 2 1983</b>		
Homes, P.A., Bethesda, Maryland				25. REGISTRAR'S SIGNATURE <b>John J. Canine</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 8 7 9	
1. STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Victor Richard Evans			2a. DATE OF DEATH MONTH DAY YEAR APRIL 23 '83		2b. HOUR 24 M
3. SEX Male	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR July 27 1923		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? United States	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Washington Grove	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 331 Ridge Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Chief Electrician		12b. KIND OF BUSINESS OR INDUSTRY WITG-TV
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Grove	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Evans			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Isabel J. Scott		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II	17. INFORMANT ADDRESS Penelope S. Evans Wife same as 13c		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) <i>Cardiopulmonary arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma of the stomach</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 3 minutes					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Pneumonia, alcohol, spread of cancer to liver, lung, abdomen.</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> 19 <i>83</i> to <i>April 23</i> 19 <i>87</i> , that (I) (we) lost saw the deceased alive on <i>April 20</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Ruben C. Cosca</i>		DEGREE M.D.		22c. DATE SIGNED April 23, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Ruben C. Cosca, M.D.		22e. ADDRESS 17529 Redland Road Derwood, Maryland 20855			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE April 24, 1983	23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR APR 26 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

Robert A. Paine

Robert A. Paine

Faint, illegible text and markings on lined paper, possibly bleed-through from the reverse side. Includes a circular stamp on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner will be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 3 1 0 8 8 0	
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			
FIRST <u>June</u> MIDDLE <u>F.</u> LAST <u>Everett</u>			MONTH <u>April</u> DAY <u>7</u> YEAR <u>1983</u>			
3. SEX <u>Female</u>			2b. HOUR <u>2 50</u> AM <u>M</u>			
4. RACE <u>White</u>			6. AGE (IN YEARS LAST BIRTHDAY) <u>58</u> YRS.			
5. DATE OF BIRTH MONTH <u>June</u> DAY <u>6</u> YEAR <u>1924</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Michigan</u>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.			
7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>			
10. CITY OR TOWN OF DEATH <u>Bethesda</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>At Home</u>			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>			13a. STREET ADDRESS <u>20854</u> <u>11110 South Glen Road</u>			
12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>Md.</u> CITY OR TOWN <u>20854</u> COUNTY <u>Montgomery</u>			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST <u>Frank</u> MIDDLE <u>---</u> LAST <u>Finten</u>			15. MOTHER'S MAIDEN NAME FIRST <u>Julia</u> MIDDLE <u>---</u> LAST <u>Wilson</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>			16b. SOCIAL SECURITY NO. <u>579-38-2983</u>			
17. INFORMANT ADDRESS <u>Glenn D. Everett, Same address as #13.</u>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio Respiratory Arrest</u> <u>1919</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Glioblastoma</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 mo.</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/6</u> , 19 <u>83</u> , to <u>4/7</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>4/6</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.						
22b. SIGNATURE <u>Carol Bender</u> DEGREE				22c. DATE SIGNED <u>4/7/83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Carol L. Bender</u>				22e. ADDRESS <u>11510 Old Georgetown Rd., Bethesda, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial/Transit</u>		23b. DATE <u>4/11/83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		
23d. LOCATION CITY OR TOWN COUNTY STATE <u>Sandusky, Ohio</u>		24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc.</u> <u>5130 Wisconsin Ave., NW, Washington, D.C. 20016</u>				
25a. DATE REC'D. BY REGISTRAR <u>APR 13 1983</u>				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>		

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20% COTTON FIBRE

CHILFAM



230 Wisconsin Ave., N.W., Washington, D.C. 20005  
General Manager, Inc.  
Printed in U.S.A.

San Francisco, Calif.

San Francisco, Calif.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 8 8 1			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST				MONTH DAY YEAR 2b. HOUR			
CLINTON LeRoy EWING, Jr.				4 14 83 1 A M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		Caucasian		Sept. 26, 1926		56 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		United States				MONTGOMERY County, MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN HOSPITAL		Regional Mgr.		Pharmaceutical	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST)		15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)		13e. STREET ADDRESS			
Clinton LeRoy Ewing, Sr.		Carlin Reuschlein		8024 Hampden Lane (20814)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		WW II		Irene C. Ewing, same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a)		HEPATO RENAL FAILURE		2 WEEKS			
4549		DUE TO, OR AS A CONSEQUENCE OF (b)		FIRST: 6 WEEKS			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		VARICEAL HEMORRHAGE		SECOND: 1 WEEK			
		DUE TO, OR AS A CONSEQUENCE OF (c)		6 MONTHS			
		CIRRHOSIS					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
HEPA RESPIRATORY FAILURE; HEMORRHAGIC PLEURAL EFFUSION - LUNG INFARCTION							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
3/31/83		HEMORRHAGIC PLEURAL EFFUSION		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 3/2, 1983, to 4/13, 1983, that (I) (we) lost the deceased alive on 4/13, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Alan N. Schulman				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		Apr. 14, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
ALAN N. SCHULMAN				9715 MEDICAL CENTER DRIVE - SUITE 404 ROCKVILLE, MD 20850			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		April 15, 1983		Metropolitan Crem.		Alexandria, Virginia	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814				APR 21 1983		[Signature]	

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CHIEF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please relieve carbinappers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 8 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Arnold NMN Farley</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4/25/83</b>		2b. HOUR <b>235</b> P.M.	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7 11 1913</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Kentucky</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Claim Consultant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>V.F.W.</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spr.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Tissac Farley</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rachel Unknown</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>WW IT 405-01-8793</b>		17. INFORMANT <b>#1608 Vivign A. Farley Sil. Spr., Md. 20910</b>			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Respiratory Failure</b> <b>4169</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cor Pulmonale</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b>							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4/25/83</b> P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>4/25/83</b> to <b>4/25/83</b> , the (1) (we) last saw the deceased alive on <b>4/25/83</b> and (not in my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>David Cromwell</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/25/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>David Cromwell, M. D.</b>				22e. ADDRESS <b>831 University Blvd. E. Sil. Spr., Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>4/28/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory Alexandria, Va.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Keith H. Watkins</b> ADDRESS <b>P.O. Box 7428 Warner E. Pumphrey, Inc., Sil. Spr., Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 29 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

BP



Item #166 Film G579 5/10/83 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 8 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ELSIE White FARRELL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>04 26 83</b>			2b. HOUR <b>3 1/2</b> M.			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 4, 1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Treasurer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Health &amp; Physics Service Inc.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1004 Aster Blvd. 20850</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Francis J. White</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elsie Clayton</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. (IF YES, GIVE WAR OR DATES) <b>WWII</b>		16c. SOCIAL SECURITY NO. <b>109-20-2088</b>		17. INFORMANT ADDRESS <b>John R. Farrell Husband Same as item 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4912 Cardio-respiratory Failure</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Severe Chronic Obstructive Pulmonary Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Bronchitis</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>20 1 yr. 5 yrs</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (d) <b>Acute Ischemic + congestive heart failure</b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>7/2/1976</b> to <b>4/26/83</b> , that (I) (we) lost saw the deceased alive on <b>4/23/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Stephen N. Jones</b>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/26/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Stephen N. Jones, M.D.</b>						22e. ADDRESS <b>809 Viers Mill Road Rockville, Maryland</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>April 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Maryland</b>		
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



MADE IN U.S.A.

100% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 8 8 4	
1- FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST Mary		MIDDLE Elson		LAST Farwell		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
								April 27, 1983		3:10 PM	
3 SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		June 12, 1904		78 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Mass.		U.S.A.				Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda		Fernwood House		Secretary		Cannalier					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md. 20906		Montgomery		Silver Spg.				15300 Beverbrook Ct.		20906	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Stewart Elson				Hazel May Pike							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				011-03-0041		Leota Kirby 14227 Briarwood Terr. Rock., Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4360 } DUE TO, OR AS A CONSEQUENCE OF (b) <u>multiple strokes</u>										weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>cerebral arterio Sclerosis</u>										years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 19 61 to 4-27 19 83, that (I) (we) lost saw the deceased alive on 4-24 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Russell M. Tilley, Jr. M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/27/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell M. Tilley, Jr.				22e. ADDRESS 4701 Mass. Ave., N.W., Washington, D.C.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/28/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE		Suitland, Md.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Was., D.C. 20016						25a. DATE REC'D. BY REGISTRAR MAY 2 1983 REGISTRAR'S SIGNATURE <u>John J. Canfield</u>					

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CHIEF 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained until 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 22 shows any injury, or other traumatic event, the fileable must be submitted to the notified office.

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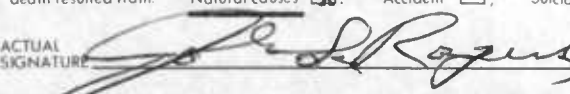

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 8 8 5	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>SOPHIA</b>				FIRST <b>FEIRSTEIN</b>				LAST			
2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 15, 1983</b>				2b. HOUR <b>7:10 AM</b>							
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>SEPTEMBER 23, 1907</b>				6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.			
10. CITY OR TOWN OF DEATH <b>POTOMAC</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>8909 COPENHAVER DRIVE</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>POTOMAC</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>8909 COPENHAVER DRIVE</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>(UNASCERTAINABLE)</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>(UNASCERTAINABLE)</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>579-48-5279</b>		17. INFORMANT <b>ROBERT FEIRSTEIN, POTOMAC, MARYLAND</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic colon cancer</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 months</b>	
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) <b>colon cancer</b>										5 1/2 yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 31</b> 19 <b>82</b> , to <b>April 14</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>Feb. 28</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If yes) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Philip Cohen</b>				DEGREE				22c. DATE SIGNED <b>4/15/83</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DR. PHILIP COHEN, M. D.</b>				22e. ADDRESS <b>2150 PENNSYLVANIA AVENUE, N. W. WASHINGTON, D. C. 20037</b>							
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>				23b. DATE <b>4/17/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH DAVID CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>ELMONT, LONG ISLAND, NEW YORK</b>			
24. FUNERAL DIRECTOR <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>						25. DATE REC'D. BY REGISTRAR <b>APR 19 1983</b>		25. REGISTRAR'S SIGNATURE <b>John J. Cohen</b>			
26. ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>											

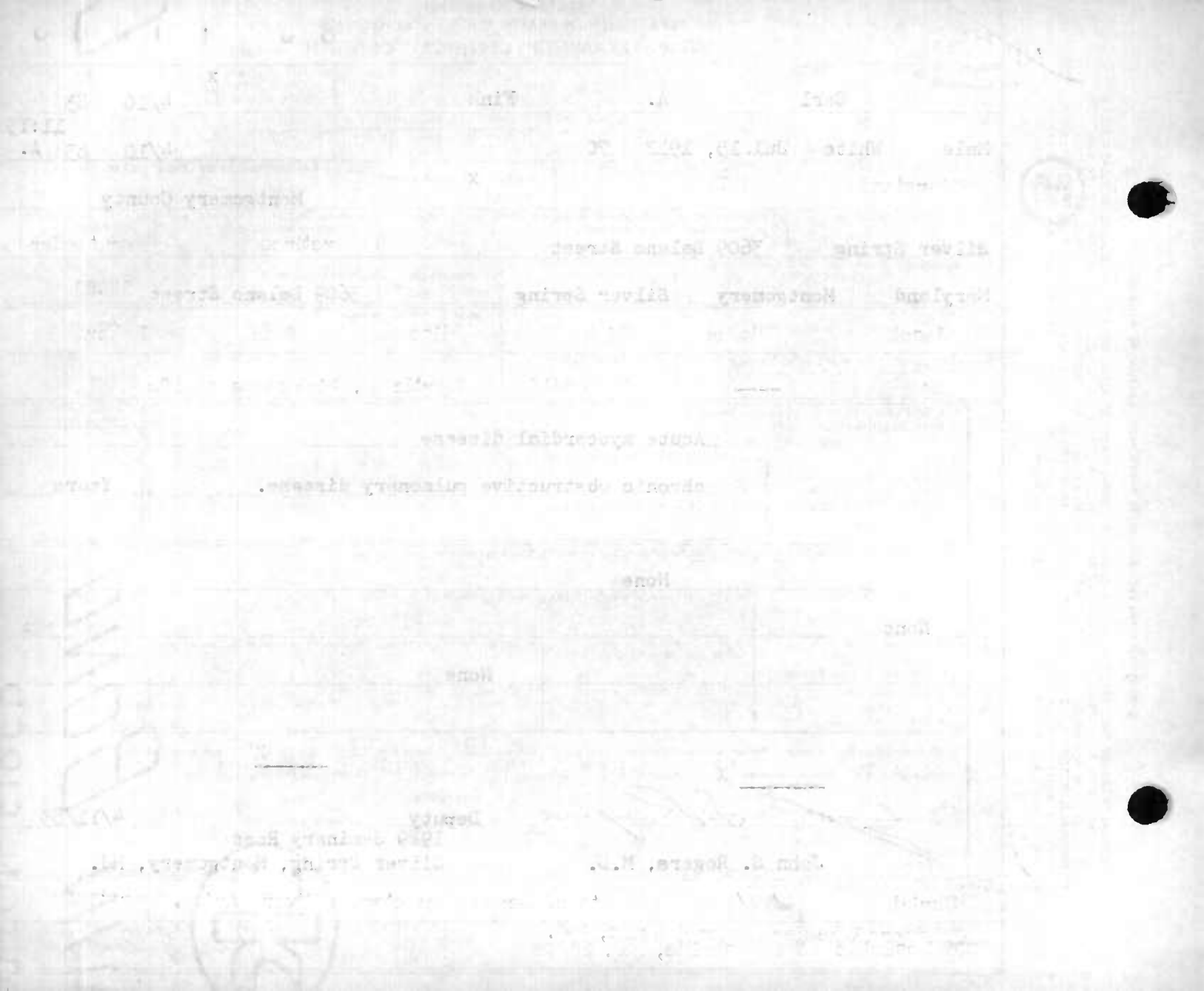
APR 19 1968

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10886	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Carl A. Fink</b>										20. DATE KNOWN OF DEATH MONTH DAY YEAR <b>4/10 19 83</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jul. 15, 1912</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>70 YRS.</b>		7. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4/10 19 83</b>		21. HOUR <b>11:15 A.M.</b>	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>3609 Delano Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>bar tender</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3609 Delano Street 20902</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jacob Elmer Fink</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Alice Mae Baker</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>577 05 2412</b>		17. INFORMANT ADDRESS <b>Myrtle M. Fink same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4960</b> IMMEDIATE CAUSE (a) <b>Acute myocardial disease</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>chronic obstructive pulmonary disease.</b> (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. <b>Deputy</b>				DATE SIGNED <b>4/11/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>1919 Seminary Road Silver Spring, Montgomery, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4/13/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Wheeler Funeral Home, Inc.</b> ADDRESS <b>1331 Rockville Pike Rockville, Md. 20852</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b>		25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 8 8 7 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MAY M. Flickinger				2a. DATE OF DEATH MONTH DAY YEAR 4 22 13				2b. HOUR 6 45 AM			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 10 97		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bel Pu Health Care Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST William Dubs				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Grove				13303 Justice Road 20853			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-56-3610		17. INFORMANT ADDRESS Alvin E. Flickinger Son Same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY: 4860 IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 80 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 3 Crochets Melts: Hemiplegia, arthralgias, neurop											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 17 19 83 to April 22 19 83, that (I) (we) last saw the deceased alive on April 17 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael A. Dobnig				DEGREE M.D.		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED April 22 83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Dobnig M.D.				22e. ADDRESS 13975 Conn. Ave Silver Spring, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE April 25, 1983		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Montgomery Md.			
24. FUNERAL DIRECTOR NAME Francis J. Collins				ADDRESS 500 University Blvd. W. Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR APR 28 1983		25b. REGISTRAR'S SIGNATURE John J. Gair	

BP

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LIBRARY

14



UNIVERSITY OF CHICAGO LIBRARY



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the Registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

Item #12b Film G579 5/6/83 re		STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8 3 1 0 8 8 8	
1. STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST William James Forbes				MONTH DAY YEAR 4-20-83		6:15 Mp	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
Male		White		MONTH DAY YEAR 4 20 10		73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Colorado		U.S.A.				Montgomery MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda Maryland		Suburban Hospital		Comptroller		Post Office Hospital	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
D.C.		Washington		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3343 Legation St. N.W.	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST Reginald Love Forbes		FIRST MIDDLE LAST Lillian Pearl Bailey					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			
Yes		W.W. 11 437-09-7356		3343 Legation St. N.W. Washington D.C.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4140		Cardiac Arrest		Sudden			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b). DUE TO, OR AS A CONSEQUENCE OF		Arteriosclerotic Heart Disease		20 years	
		(c). DUE TO, OR AS A CONSEQUENCE OF					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
Renal Disease (unknown type) with uremia; Chronic Bronchitis and Emphysema							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from		October 19 75		to April 20 19 83		that (I) (we) last saw the deceased alive on	
above, (1) (we) (did) (did not) view the body after death.		April 20 19 83		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated			
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
John F. Gustafson M.D.		M.D.				20 April 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
John F. Gustafson M.D.		5480 Wisc. Ave. Chevy Chase, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Cremation		4/21/83		Cedar Hill Crematory		Suitland, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc.		APR 25 1983		John J. Connel			
NAME		5130 Wisc. Ave. N.W. Wash., D.C.					



100% COTTON



APR 25 1983

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 8 9

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Frances H. Fox</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-1-83</b>			2b. HOUR M <b>M</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 3 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Ret'd Clerk</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>		16. STREET ADDRESS <b>530 Calvin Lane 20851</b>			
17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		17b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>290-20-5389</b>		17. INFORMANT ADDRESS <b>Michael McGinley 530 Calvin Lane Rockville, Md. 20851</b>			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Accident</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (b)							
19a. DATE OF OPERATION <b>3/31/83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cardiovascular</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (i) this hospital attended the deceased from <b>3/31/83</b> to <b>4/1/83</b> , that (ii) we last saw the deceased alive on <b>3/31/83</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)							
22b. SIGNATURE <b>GARY W. LONER</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/1/83</b>	
22d. PHYSICIAN'S STAMP (TYPE OR PRINT) <b>GARY W. LONER</b>		22e. ADDRESS <b>8200 Wisconsin Ave.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>4/2/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Geo. Wash. Univ. Med.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>Columbia Mortuary Services</b>		24b. ADDRESS <b>225 Missouri Ave. N.W.</b>		24c. DATE REC'D. BY REGISTRAR <b>APR 7 1983</b>		24d. REGISTRAR'S SIGNATURE <b>John D. [Signature]</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use at the burial/cremation permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 21 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. The first part of the document is a list of names and dates, which appears to be a roster or a list of participants. The names are written in a cursive script, and the dates are written in a more formal, printed style. The list is organized into two columns, with names on the left and dates on the right.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrars after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 10890	
FOR 1. STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Minnie M. Friess						2a. DATE OF DEATH MONTH DAY YEAR April 15, 1983			2b. HOUR 6:30AM		
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Oct. 30, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8606 Grant Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Home		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. STREET ADDRESS 8606 Grant Street 20817					
14. FATHER'S NAME FIRST MIDDLE LAST William Pier						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah Tinsman					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 578-01-6560		17. INFORMANT ADDRESS Adam L. Friess, same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart failure</i> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 10 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <i>Diabetes Mellitus, Chronic urinary tract infection</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>June 1967</i> to <i>April 1983</i> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <i>March 1983</i> and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <i>Marvin Wadler</i>						DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/15/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marvin Wadler, M.D.						22e. ADDRESS 8218 Wisconsin Avenue Bethesda, Maryland 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 18, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cem				23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring, Maryland			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Homes, P.A. Bethesda, Maryland 20814						25a. DATE REC'D. BY REGISTRAR APR 21 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>			



CHIEF

EX-101

APR 21 1963



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEAR, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
30M 7/73

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE KNOWN OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Rebecca				Frieling	DATE KNOWN OF DEATH		4	23	83	6:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE IN YEARS	IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		
F	W	6 15-82		100 YRS.	MONTHS DAYS		HOURS MIN.		4-23-83 19		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
Austria		U.S.A.			WIDOWED		DIVORCED		Montgomery		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Wheaton		Randolph Hills Nursing Home				Assembly Line Work		Western Elec.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Montgomery		Wheaton		YES		4011 Randolph Rd.		20902	
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		MIDDLE		LAST	
Max				Wagshal		Pape				Epstein	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		4924 Sentinel Dr.			
NO		028-20-4988-A		Julius Schlezinger		Bethesda, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4100 IMMEDIATE CAUSE (a) Cardiac arrest.											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.											
(b) Coronary Thrombosis.											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
Fractured left hip.											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
										YES NO	
21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		21d. INJURY OCCURRED					
UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					
WHILE AT WORK NOT WHILE AT WORK		P.M. 3-21 1983		21f. LOCATION		21g. CITY OR TOWN					
				Nursing Home		4011 Randolph Rd. Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY)								DATE SIGNED	
John Tauber		M.D. MEDICAL EXAMINER								4-23-83	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS								8218 WISCONSIN.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		April 25, 83		King David Mem. Garden Falls Church		Va.					
24. FUNERAL DIRECTOR		25a. DATE DIRECTED BY REGISTRAR								25b. REGISTRAR'S SIGNATURE	
NAME Danzansky-Goldberg Mem. Chapels		ADDRESS 1170 Rockville								APR 26 1983	
		Rockville, Md.									



M

RECEIVED

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 9 2

FOR  
1. STATE  
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) <b>Catherine - Gallagher</b>		LAST <b>GALLAGHER</b>		DATE OF DEATH MONTH DAY YEAR <b>4 23 83</b>		HOUR <b>8 15 A M</b>	
SEX <b>FEMALE</b>		RACE <b>WHITE</b>		DATE OF BIRTH MONTH DAY YEAR <b>AUG. 18, 1908</b>		AGE (IN YEARS LAST BIRTHDAY) <b>74</b> YRS.	
BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ireland</b>		CITIZEN OF WHAT COUNTRY? <b>USA</b>		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
CITY OR TOWN OF DEATH <b>Olney</b>		NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1 BROOKE GROVE N.H.</b>		USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Page</b>		KIND OF BUSINESS OR INDUSTRY <b>Bank</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>N. J. 08733</b>		13b. COUNTY <b>Manchester</b>		13c. CITY OR TOWN <b>Lakehurst</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William - Meegan</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary - McNicholas</b>		17. INFORMANT ADDRESS <b>17504 Timberleigh Way Woodbine, Md. 21797</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>107-14-0935</b>		17. INFORMANT <b>Maureen Smith</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PULMONARY CONGESTION</b> <b>1919</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ASTROCYTOMA GRADE III</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>1 1/2</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION <b>1-6-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BRAIN TUMOR</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>9/28/82</b> to <b>4/23/83</b> , that (I) (we) lost saw the deceased alive on <b>4/23/83</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Donald R. Lewis MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/23/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD R. LEWIS MD</b>		22e. ADDRESS <b>OLNEY MD 20832</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APR. 27, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Joseph Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Toms River Ocean N. J.</b>	
24. FUNERAL DIRECTOR <b>FRANCIS H. BARBER</b>		LAYTONSVILLE, MD. 20879		25a. DATE REC'D. BY REGISTRAR <b>APR 27 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	



FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 8 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>EMELINA (NMN) GARCIA</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 15, 1983</b>			2b. HOUR <b>1:50AM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>October 14, 1939</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>43</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Columbia, S. Am</b>		7b. CITIZEN OF WHAT COUNTRY? <b>South America</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Clinical Center, NIH, Beth., MD</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housekeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Washington, DC</b> 13b. COUNTY <b>Washington</b> 13c. CITY OR TOWN <b>Washington</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1908 Florida Ave NW 20009</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Eusebio Garcia</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Jovita De Garcia</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212-84-3571</b>		17. INFORMANT (husband) ADDRESS <b>Mr. Miguel Ramierz Columbia, SA</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4240 IMMEDIATE CAUSE (a) Adult Respiratory Distress Syndrome</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Acute Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Status-post Mitral valve replacement for Mitral Regurgitation</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Day</b>	
								<b>1 week</b>	
								<b>10 days</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>Systemic Lupus Erythematosus - 12 Years</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <del>it</del> (this hospital) attended the deceased from <b>March 14, 1983</b> to <b>April 15, 1983</b> , that <del>it</del> (we) lost <del>saw</del> the deceased alive on <b>April 15, 1983</b> , and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above. <del>It</del> (we) (did) <del>not</del> view the body after death.									
22b. SIGNATURE <b>Joseph A. Kovacs</b> DEGREE <b>MD</b>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <b>4/17/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joseph A. Kovacs</b>				22e. ADDRESS <b>National Institutes of Health Clinical Center, Bethesda, MD 20205</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-23-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Harmony Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Landover, Md.</b>			
24. FUNERAL DIRECTOR <b>Marshall's Funeral Home</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 26 1983</b>		25b. REGISTRAR'S SIGNATURE <b>Joan J. Conish</b>			
4217 9th St NW: Washington, D.C.									

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		7. REG. NO. 8310894							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Marguerite M. Garlinghouse</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4-14-1983</b>		2b. HOUR <b>1245A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 22 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <b>90</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Livonia Center, N. Y.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Potomac</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac Valley Nurshing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIS MACNAIR</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EMMA PATTERSON</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>None</b>		17. INFORMANT <b>Mrs. Nancy D. Shaw, Dtr.</b>		ADDRESS <b>8808 Wooden Bridge Rd/Potomac, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>STROKE</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE TIME BETWEEN ONSET <b>20854</b> <b>1 month</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>14 Feb</b> , 19 <b>83</b> , to <b>14 April</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>20 March</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James Mackin</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>14 April 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>James F. Mackin MD</b>				22e. ADDRESS <b>5401 Western Ave, Chevy Chase, Md.</b>					
23a. CREMATION, <del>YES</del> <del>NO</del> (SPECIFY) <b>Cremation</b>		23b. DATE <b>Apr. 14, 1983</b>		23c. NAME OF <del>CREMATOR</del> CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Prince Geo, Md.</b>			
24. FUNERAL DIRECTOR <b>W. W. Chambers Co, Inc 8655 Georgia Ave, S.S.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 18 1983</b> REGISTRAR'S SIGNATURE <b>John J. Casper</b>					









TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Eleanor</b>			First Middle Last			2a. DATE OF DEATH Month <b>April</b> Day <b>28</b> Year <b>1983</b>			2b. HOUR <b>3:30</b>		
3. SEX <b>Female</b>			4. RACE <b>Caucasian</b>			5. DATE OF BIRTH <b>Dec. 8, 1902</b>			6. AGE (In years last birthday) <b>80</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>Saginaw, Mich.</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Montgomery</b> Md.		
10. CITY OR TOWN OF DEATH <b>Columbia</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>5821 Harness Court</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker Ret.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. USUAL RESIDENCE (Where deceased lived, institution: Residence before admission), STATE <b>Maryland</b>			13b. CITY OR TOWN <b>Columbia</b>			13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			13e. STREET AND NUMBER <b>5821 Harness Ct. 21044</b>		
14. FATHER'S NAME <b>GEORGE</b>			First Middle Last			15. MOTHER'S MAIDEN NAME <b>MARGARET</b>			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No</b>			16b. SOCIAL SECURITY NO. <b>381-52-9695</b>			17. INFORMANT <b>Carol M. Gehringer, Dtr.</b>			Address <b>S. S. Md. 20910. 9413 Colesville, Rd.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1619</b> IMMEDIATE CAUSE (a) <b>Cancer of The Stomach</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 23, 1983</b> , to <b>April 28, 1983</b> , that (I) (we) last saw the deceased alive on <b>April 23, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Michale Peskin</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>April 28, 1983</b>		
22d. PHYSICIAN'S NAME (Type) <b>Michale Peskin MD</b>						22e. ADDRESS <b>1109 Spring Street, Silver Spring, Md.</b>					
23a. BURIAL <input checked="" type="checkbox"/> CREMATION <input type="checkbox"/> (Specify)			23b. DATE <b>May 2, 1983</b>			23c. NAME OF CEMETERY OR CREMATOR <b>Home Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Bay County, Michigan</b>		
24. FUNERAL DIRECTOR <b>W. W. Chambers Co, 8655 Georgia Ave, S. S. Md. 20910</b>						25a. REC'D BY REGISTRAR <b>MAY 2 1983</b>			25b. REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>		



RESCUE  
COTTON  
FIBER  
FARM

2000 2 2 PM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR					DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 3 1 0 8 9 7				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR				
FIRST MIDDLE LAST John WILLIAM Gibbons					MONTH DAY YEAR 4-19-83					7:40 PM				
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MARCH 16, 1907 <sup>EAR</sup>		6. AGE (IN YEARS LAST BIRTHDAY) 76		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) UTAH		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.								
10. CITY OR TOWN OF DEATH TAKOMA PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PUBLIC RELATIONS		12b. KIND OF BUSINESS OR INDUSTRY HIWAY USERS								
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9504 CROSBY ROAD 20910						
14. FATHER'S NAME FIRST MIDDLE LAST JOHN GIBBONS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET STUART												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 307-09-3936		17. INFORMANT MARCELLA GIBBONS		ADDRESS SAME AS 13		WIFE						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Metastatic Lung Cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5 months</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (1) this hospital attended the deceased from <u>15 Jan 83</u> to <u>19 April 83</u> , that (2) (we) lost saw the deceased alive on <u>19 April 83</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) did not view the body after death.														
22b. SIGNATURE <u>Thomas A. Bensinger</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/20/83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS A. BENNINGER				22e. ADDRESS 7676 New Hampshire Ave Langley Park MD 20817										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 4/22/83		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD								
24. FUNERAL DIRECTOR NAME ADDRESS FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901				25a. DATE RECD. BY REGISTRAR APR 28 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>								

BP \_\_\_\_\_



*[Faint, illegible handwriting throughout the page, possibly bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LISA LOUISE GIBSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 17 1983</b>		2b. HOUR <b>4:42 P<sub>M</sub></b>
3. SEX <b>FEMALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APRIL 16 1983</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>1</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY MD.</b>	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Infant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>VIRGINIA</b>	13b. COUNTY <b>FAIRFAX</b>	13c. CITY OR TOWN <b>ALEXANDRIA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>2434 WINDBREAK DRIVE, ALEXANDRIA, VA 22306</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM LEWIS GIBSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>DEANE LOUISE KIMBLETON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>	16b. SOCIAL SECURITY NO. <b>-</b>	17. INFORMANT ADDRESS <b>WILLIAM L. GIBSON, 2434 WINDBREAK DRIVE</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

ALEXANDRIA, VA 22306

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

7597

IMMEDIATE CAUSE (a) **MULTIPLE ANOMALIES**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 16</b> , 19 <b>83</b> , to <b>APRIL 17</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>APRIL 17</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Brian G. Orr</i>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>April 19, 1983</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BRIAN G. ORR, LT. MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>	

23a. <del>DECEASED</del> CREMATION, <del>NO</del> <input checked="" type="checkbox"/> (SPECIFY) <b>Cremation</b>	23b. DATE <b>Apr. 20, 1983</b>	23c. NAME OF <del>DECEASED</del> CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P. G. Cty., Md.</b>
24. FUNERAL DIRECTOR NAME <b>W.W. CHAMBERS CO., 8655 Ga. Ave. SS, Md. 20910</b>		25a. DATE REC'D BY REGISTRAR <b>APR 21 1983</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					8 3 1 0 8 9 9				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
Myrtle Sickles Gill					4/14/83				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7b. HOUR	
Female		White		June 3, 1894		88		2:00 AM	
7a. BIRTHPLACE		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH			
New Jersey		United States		NEVER MARRIED		Montgomery County			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		SUBURBAN Hospital		Teacher		Public Schools			
13a. USUAL RESIDENCE		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Montgomery		Bethesda		YES		7912 Robison Road	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Grandon		Annie H. Hulsehart		no		142-30-5123		Mrs Roger Nelson	
18. CAUSE OF DEATH		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular arrest</u> 4292 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>atherosclerotic cardiovascular disease</u> 20 years PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>cerebrovascular disease</u>						YES		YES	
21a. ACCIDENT WAS UNDERLYING		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED		22a. DATE SIGNED			
OR CONTRIBUTING CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		4/17/83			
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION		22b. PHYSICIAN'S NAME		22c. ADDRESS	
WHILE AT WORK		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE		Samuel D. Goldberg		11125 Rockville Pike Rockville Md	
22a. I certify that (I) (this hospital) attended the deceased from		22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME		22e. ADDRESS	
4/13/83, to 4/17/83, that (I) (we) lost		Samuel D. Goldberg		4/17/83		Samuel D. Goldberg		11125 Rockville Pike Rockville Md	
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. DATE REC'D. BY REGISTRAR	
Burial		April 20, 1983		Glenwood Cemetery		West Long Branch New Jersey		APR 21 1983	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. DATE REC'D. BY REGISTRAR		25d. REGISTRAR'S SIGNATURE	
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland		APR 21 1983		John J. Smith		APR 21 1983		John J. Smith	

BP



DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
Cleared by Dr. Rogers Med. Exam  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be assigned within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
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1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 0 0  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Rita Marie Gilliam			2a. DATE OF DEATH MONTH DAY YEAR 3/18/83		2b. HOUR 7:20p M
3. SEX female	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1923		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spr.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife	12b. KIND OF BUSINESS OR INDUSTRY home
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. STREET ADDRESS 2121 Shorefield Rd. 20902
14. FATHER'S NAME FIRST MIDDLE LAST James Reed		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Sullivan			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219-36-9021		17. INFORMANT ADDRESS George O. Gilliam same as 13c	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO PULMONARY ARREST</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>ACUTE MYOCARDIAL INFARCTION</u> (c) <u></u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>3/18/83</u> , 19 <u>83</u> , to <u>3/18/83</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>3/18/83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Robert F. Larkin MD		DEGREE		22c. DATE SIGNED 3/20/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT F. LARKIN MD		22e. ADDRESS HOLY CROSS HOSPITAL 1500 FOREST GLEN RD SILVER SPRING, MD			

23a. BURIAL, CREMATION, REMOVAL (RECEIVED) Burial	23b. DATE 3/22/83	23c. NAME OF CEMETERY OR CREMATORY Parklawn Memorial Park	23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland
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Funeral Director Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland		25a. DATE REC'D. BY REGISTRAR MAR 28 1983	REGISTRAR'S SIGNATURE John J. Larkin
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 9 0 1	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	
FIRST MIDDLE LAST				MONTH DAY YEAR	
THEOLA FAYE GLEZEN				APRIL 29 83	
3 SEX		4 RACE		5. DATE OF BIRTH	
FEMALE		CAUCASIAN		MONTH DAY YEAR	
FEMALE		CAUCASIAN		DEC 04 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
PENNSYLVANIA		USA		6. AGE (IN YEARS LAST BIRTHDAY)	
PENNSYLVANIA		USA		63 YRS.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
BETHESDA		NAVAL HOSPITAL BETHESDA, MD		MONTGOMERY MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		12b. KIND OF BUSINESS OR INDUSTRY		12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN	
VIRGINIA		ARLINGTON		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13d. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		99999	
JOHN SCOTT ROHM II		ALICE ROBERTA BOLLMAN		200 FILLMORE ST ARLINGTON, VA	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
NO		170-12-8330		GLENN F. GLEZEN	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		17a. ADDRESS	
PART I. DEATH WAS CAUSED BY:				200 FILLMORE ST ARLINGTON, VA	
IMMEDIATE CAUSE (a) OVARIAN CARCINOMA					
1830					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b)			
		DUE TO, OR AS A CONSEQUENCE OF			
		(c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		P.M. 19		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from		18 MARCH 19 83		to 29 APRIL 19 83	
saw the deceased alive on		29 APRIL 19 83		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.	
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Ronald L. Thomas MD		MD		30 APRIL 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. ADDRESS	
RONALD L. THOMAS		NAVAL HOSPITAL, NAVAL MEDICAL COMMAND		NATIONAL CAPITAL REGION, BETHESDA, MD 20814	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		May 3, 1983		Arlington National	
24. FUNERAL DIRECTOR		23d. LOCATION		23e. LOCATION	
NAME ADDRESS		CITY OR TOWN COUNTY STATE		CITY OR TOWN COUNTY STATE	
Arlington Funeral Home		Arlington, Va.		Arlington, Virginia	
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	
MAY 9 1983		John J. Carter		John J. Carter	





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED. WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST JENNIE		MIDDLE		LAST GOLLOBIN		2a. DATE KNOWN OF DEATH		ESTIMATED <input checked="" type="checkbox"/> MONTH 4 24 83 19		2b. HOUR 2:25 P.M.	
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 12 25 96		6. AGE (IN YEARS) LAST BIRTHDAY 86 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 24 83 19		7d. HOUR 5:45 P.M.			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.							
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RANDOLPH HILLS NH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY Bakery					
13a. STATE MD				13b. COUNTY MONT		13c. CITY OR TOWN ROCKVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6710 Bradley Blvd. (20817)			
14. FATHER'S NAME FIRST MIDDLE LAST ABRAHAM LEVINE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) -----		17. INFORMANT CATHARINE ALESSI, RN		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4149 IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). NONE													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE John Given				TITLE (SPECIFY) M.D. Deputy				MEDICAL EXAMINER				DATE SIGNED 4/24/83	
EXAMINER'S NAME (TYPE OR PRINT) John Given				ADDRESS 1516 Pinyard Hill Rd.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 4/26/83		23c. NAME OF CEMETERY OR CREMATORY Judean Memorial Gardens				23d. LOCATION CITY OR TOWN COUNTY STATE Olney; Montgomery; Maryland			
24. FUNERAL DIRECTOR NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS				1170 Rockville Pike; Rockville, Md. 20852				25a. DATE REC'D. BY REGISTRAR APR 28 1983		25b. REGISTRAR'S SIGNATURE John J. Conner			

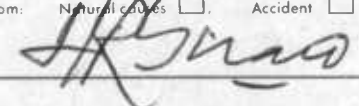

SECTION

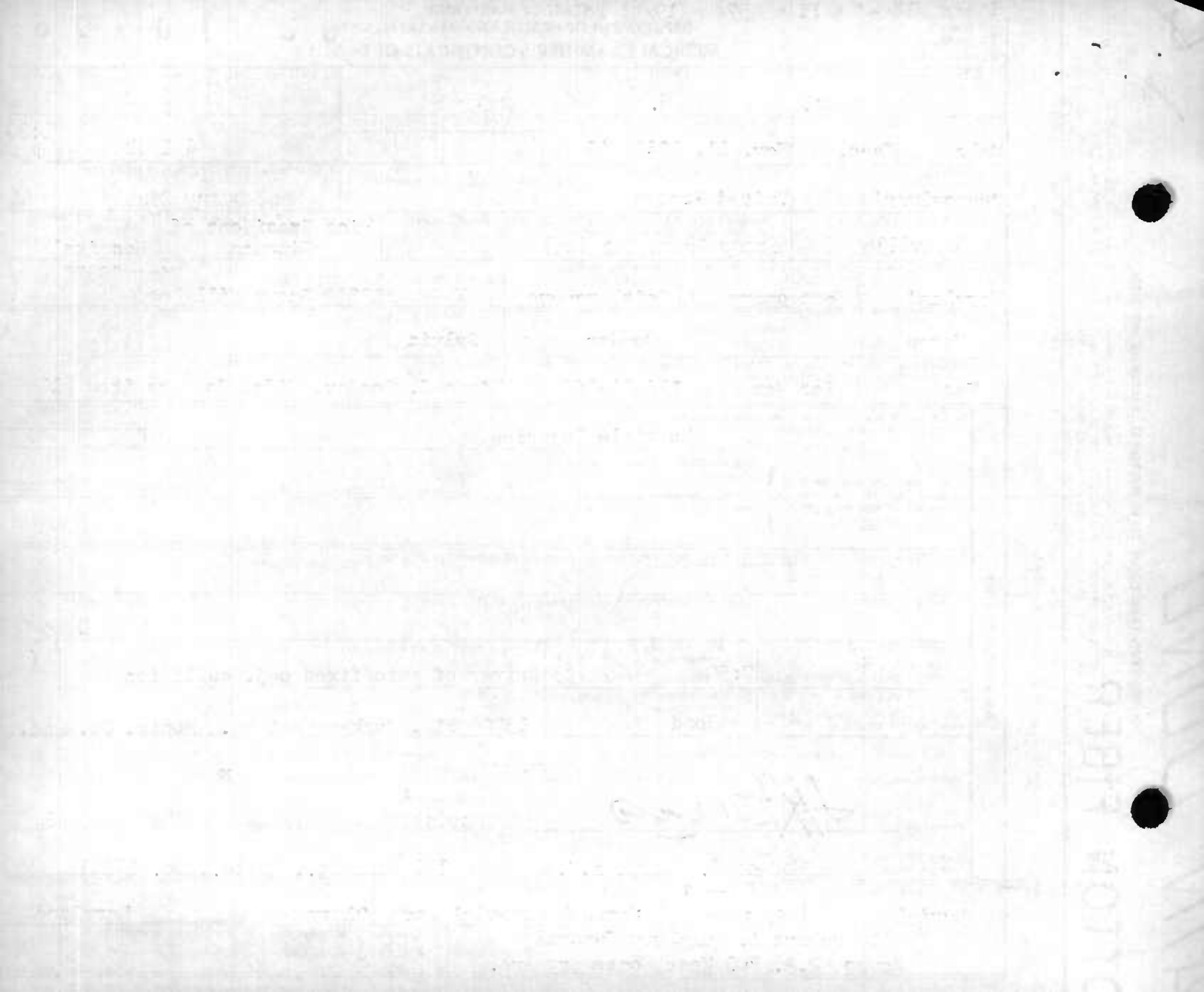
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APR 8 1904

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 10. IF THE EXAMINER IS NOT AVAILABLE, THE FUNERAL DIRECTOR SHOULD BE FILED AS A BURIAL - TRANSIT PERMIT. PAGES 1, 2, AND 3 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP 268

FOR DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Robert M. Gonder</b>												2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>4/2/83</b> 19	2b. HOUR P M <b>8:30</b>
3 SEX <b>Male</b>	4. RACE <b>Cauc.</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 11, 1942</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4/2/83</b> 19						7d. HOUR P M <b>8:30</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.							
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Hospital</b>				12. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING ONLY) <b>Vice President of Finance</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Hospital</b>				
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>13324 Query Mill Road</b>		Zip: <b>20878</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Maron Gonder</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sylvia Lewis</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Viet Nam</b>		17. INFORMANT ADDRESS <b>Linda J. Gonder, Wife, Same as item #13</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>Multiple Injuries</b>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>8150</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.													
DUE TO, OR AS A CONSEQUENCE OF (b)													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR <b>7:50 P.M. 4/2/1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Driver of auto/fixed obj. collision</b>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Road</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>13700 Blk. Turkey Foot Rd. Montg. Co. Md.</b>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .													
ACTUAL SIGNATURE 				TITLE (SPECIFY) M.D. <b>Assistant</b> MEDICAL EXAMINER				DATE SIGNED <b>4/4/83</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Hormez R. Guard, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>April 6, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Norbeck Memorial Park</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Olney Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral</b>						ADDRESS <b>Homes, P.A. 300 West Montgomery Ave.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 11 1983</b>		25b. REGISTRAR'S SIGNATURE 			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked, item 18 must be marked, injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	3	1	0	9	0	4	
1. FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) <b>MIGUEL BALALONG GONZALES</b>										2a. DATE OF DEATH <b>APRIL 10 1983</b>				2b. HOUR <b>6:00 P.M.</b>			
3. SEX <b>Male</b>			4. RACE <b>White</b>			5. DATE OF BIRTH <b>July 8 1925</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b>			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Philippines</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD								
10. CITY OR TOWN OF DEATH <b>Kensington</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>110008 Madison St.</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Private Industry</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Engineer</b>				
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>110088 Madison Street</b> 20895								
14. FATHER'S NAME FIRST MIDDLE LAST <b>Grogorio - Gonzales</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Naomi - Balalong</b>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW11 224 38 5025</b>			17. INFORMANT <b>Wife</b>			ADDRESS <b>Same as # 13</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Squamous Carcinoma of Lung</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>14 mos</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (the hospital) attended the deceased from <b>12</b> <b>4/6</b> <b>83</b> to <b>4/10</b> <b>83</b> , that (I) (we) last saw the deceased alive on <b>4/6</b> <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <b>G. Lennard Gold M.D.</b>										DEGREE <b>Attending Physician</b>		MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Apr. 10, 1983</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Lennard Gold M.D.</b>										22e. ADDRESS <b>8630 Fenton St. Silver Spring, Maryland</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>				23b. DATE <b>Apr. 13, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>							
24. FUNERAL DIRECTOR NAME ADDRESS <b>DeVol Funeral Home 2222 Wisconsin Washington D.C.</b>										25a. DATE REC'D. BY REGISTRAR <b>APR 19 1983</b>			25b. REGISTRAR'S SIGNATURE <b>Robert A. DeVol</b>				

J. C. I.

DOVEY, JAMES H. 1895-1965

DATE OF REVENUE

Silver Spring, Maryland

G. Leonard Gold M.D.

6050 Fenton St., Silver Spring, Maryland

2801.01.754

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1994

These 3 couples

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### Background

11000 Madison Avenue

1700 Madison St.

Private Index: Reel 100

1991:1111

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$$V_1 = V_2 = 1$$

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 9 0 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>RUSSELL GRADDICK</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 9, 1983</b>			
3. SEX <b>MALE</b>				2b. HOUR <b>1540P M</b>			
4. RACE <b>CAUCASION</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 4, 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b>		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>SOUTH CAROLINA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy</b>	
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>ARNOLD</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>1595 RITCHIE HWY. 21012</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JOHN GRADDICK</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLORENCE HENDRICKS</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>248-14-5786</b>	
17. INFORMANT <b>RUSSELL H. GRADDICK</b>		ADDRESS <b>SAA</b>		17. INFORMANT <b>ETHEL E. GRADDICK</b>		ADDRESS <b>SAA</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>1850 STAGE D PROSTATE CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 8</b> , 19 <b>83</b> , to <b>APRIL 9</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>APRIL 9</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dennis Azuma</b>		DEGREE <b>LT MC</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>09 Apr 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DENNIS AZUMA, LT, MC, USN</b>		(M.D.)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>Apr. 12, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Uniformed Services University of the Health Sciences</b>		23d. LOCATION <b>Bethesda, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Service, Falls Church, Va.</b>		ADDRESS <b>Capitol Funeral Service, Falls Church, Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 20 1983</b>		REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

BP





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 0 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. ASSED NAME (PRINT) <i>Mildred P. Green</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>4 21 83</i>		2b. HOUR <i>8:00</i>
3. SEX <i>F</i>	4. RACE <i>W</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>2 13 01</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Washington, DC</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10. CITY OR TOWN OF DEATH <i>Bethesda</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Fernwood House</i>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>		
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>	13c. CITY OR TOWN <i>Bethesda</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST <i>Horace Peyton</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Hallie Virginia Crouch</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>N/A</i>		16b. SOCIAL SECURITY NO. <i>213-54-7575 M</i>		17. INFORMANT (20783) ADDRESS <i>10926 Pleasant Acres Dr., Adelphi, Md.</i>

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1-2 hrs.</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>4100</i>		<i>4-5 days</i>
(b) <i>ATRIAL FIBRILLATION</i>		<i>YEARS</i>
(c) <i>HYPERTENSIVE ARTERIOSCLEROTIC</i>		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: *PARKINSON'S DISEASE*

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	

22a. I certify that (1) this hospital attended the deceased from *19 69* to *APRIL 21*, 19 *83*, that (1) (we) last saw the deceased alive on *APRIL 20*, 19 *83*, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>Alexander L. Matas, M.D.</i>	DEGREE <i>M.D.</i>	22c. DATE SIGNED <i>APRIL 21, 1983</i>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ALEXANDER L. MATAS</i>	22e. ADDRESS <i>4124 WARREN ST., N.W. WASHINGTON, D.C. 20016</i>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	23b. DATE <i>4-25-83</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Fort Lincoln Cemetery</i>	23d. LOCATION CITY OR TOWN COUNTY STATE <i>Brentwood Pr. Georges Md.</i>
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24. FUNERAL DIRECTOR <i>Hines/Rinaldi Funeral Home</i>	11800 N.H. Ave., Silver Spring, Md.	25a. DATE REC'D. BY REGISTRAR <i>APR 26 1983</i>	25b. REGISTRAR'S SIGNATURE <i>John J. Canale</i>
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CHIEFLY

2022 COTTON



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR		
Elizabeth Kilmore Greenbaum						4/6 19 83						10:35 P.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. HOUR		
Female	White	Jul. 26, 1968	14 YRS.			4/6 19 83						P.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
VIRGINIA			U.S.A.						Montgomery County MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park			Washington Adventist Hospital			STUDENT								
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Montgomery			Silver Spring			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			16 Sussex Road 20910		
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST					FIRST MIDDLE LAST									
LEON JACK GREENBAUM, JR.					MARY ITA GREENBAUM									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)					16b. SOCIAL SECURITY NO.					17. INFORMANT				
NO					NONE					CLARENDON RD. 20921 LEON GREENBAUM, FATHER, BETHESDA, MD. 20814				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a) Multiple injuries.														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.														
(b) DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														
None														
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?				
None										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR MONTH DAY YEAR					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
					9:10 P.M. 4/6 19 83					Passenger in automobile accident				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION CITY OR TOWN COUNTY STATE				
					Street					Sligo Avenue, Silver Spring, Montgomery, Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE										TITLE (SPECIFY)				
John S. Rogers, M.D.										Deputy MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS				
John S. Rogers, M.D.										1919 Seminary Road Silver Spring, Montgomery, Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE					23c. NAME OF CEMETERY OR CREMATORY				
BURIAL					4/13/83					ROCK CREEK CEMETERY				
24. FUNERAL DIRECTOR NAME					25. DATE REC'D. BY REGISTRAR					26. REGISTRAR'S SIGNATURE				
RICHARD RAPP, INC. WASHINGTON, D.C. 20036					APR 19 1983					7				



checked with Dr. MAYLE

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #236 Film G579 5/3/83 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10908

1- STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY E. GROFF</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 4 83</b>			2b. HOUR <b>3:40 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>August 19, 1889</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>5015 Battery Lane #405</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <b>Maryland Montgomery Bethesda</b>			13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>5015 Battery Lane #405 20814</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>James D. Hain</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah Klinefelter</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>236-07-3559</b>			17. INFORMANT <b>Son 11212 Stephalee Lane</b>			<b>J. Franklin Groff Rockville, Md. 20852</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY THROMBOSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Advanced Coronary Sclerosis 6 years</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 min</b> <b>8 hours</b> <b>6 years</b>								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Right Bundle Branch Block</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>was</del> <b>present</b> attended the deceased from <b>4/4</b> 19 <b>83</b> to <b>4/4</b> 19 <b>83</b> , that (I) <del>was</del> <b>present</b> saw the deceased alive on <b>4/4</b> 19 <b>83</b> , and that in (my) <del>own</del> <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> <b>did</b> view the body after death.									
22b. SIGNATURE <b>Frank Y. Sagers Jr MD</b>						DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/4/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>FRANK Y. SAGGERS JR</b>						22e. ADDRESS <b>6000 Executive Blvd</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>6th April 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairview Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Montgomery Pennsylvania</b>		23e. DATE REC'D. BY REGISTRAR <b>APR 11 1983</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland</b>						25. REGISTRAR'S SIGNATURE <b>John J. Conner</b>			

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows body injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8310909			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary Gertrude Grove</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>4/29/83</i>		2b. HOUR <i>5:45</i> M					
3. SEX <i>F</i>		4. RACE <i>white</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>March 11, 1886</i>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. <i>97</i>		IF UNDER 1 YEAR IF UNDER 24 HRS MONTHS DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Pennsylvania</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.							
10. CITY OR TOWN OF DEATH <i>Gaithersburg</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Wilson Health Care Center</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <i>Maryland</i>		13c. COUNTY <i>Washington</i>		13d. CITY OR TOWN <i>Hagerstown</i>		13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS <i>unknown 21740</i>					
14. FATHER'S NAME FIRST MIDDLE LAST <i>Samuel A. Gardner</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Clara V.</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <i>John W. Grove, Hagerstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>4140 Bronchopneumonia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart dis.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Generalized arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <i>Cerebrovascular Insufficiency</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>15 yrs</i> <i>25 yrs</i>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>3/18</i> to <i>4/29/83</i> that (I) (we) last saw the deceased alive on <i>4/30/83</i> and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE DEGREE <i>Henry C. Scroggins</i>		22c. DATE SIGNED <i>4/29/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i>		23b. DATE <i>May 2, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rose Hill Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Hagerstown, Wash., Maryland</i>			
24. FUNERAL DIRECTOR'S NAME <i>MINNICH FUNERAL HOME</i>				24b. ADDRESS <i>415 E. Wilson Blvd., Hagerstown, Md. 21740</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 2 1983</i>				25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>	

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JAN 10 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 15 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				8 3 1 0 9 1 0			
1. DECEASED NAME (TYPE OR PRINT) <b>Ruth Violeta Guillen R.</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 26, 1983</b>		2b. HOUR <b>10:40AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 28, 1937</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Guatemala City</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NIH, The Clinical Center</b>		12a. USUAL OCCUPATION (TYPE OF BUSINESS OR WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STREET ADDRESS			
13a. STATE <b>Washington</b>		13b. COUNTY <b>D.C.</b>		13c. CITY OR TOWN <b>D.C.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jose' Luis Guillen C.</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Marina Rodriguez</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>				16b. SOCIAL SECURITY NO. <b>102-36-9530</b>		17. INFORMANT ADDRESS <b>Miss Flor De Maria Guillen (Sister)</b>	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>2028 Hepatic failure</b> IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF <b>Probably sepsis</b> (b) DUE TO, OR AS A CONSEQUENCE OF <b>Malignant lymphoma</b> (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>3 weeks</b> <b>Several years</b>						PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>March 1, 1983</b> , to <b>April 26, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 26, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE <b>Karen G. Louie, MD</b>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/26/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KAREN G. LOUIE, MD</b>				22e. ADDRESS <b>National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20205</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-30-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Marshall's Funeral Home</b> ADDRESS <b>4217 9th St NW: Washington, DC</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 2 1983</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10911

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>SEYMOUR D. GUNOD</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>APR 29 1983</b>		2b. HOUR <b>12 03 A.M.</b>	
3. SEX <b>male</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>10 - 07 - 23</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>59</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN) <b>NEW YORK</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ATTORNEY</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>REVENUE SERVICE</b>
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13b. STREET ADDRESS <b>11511 MONTICELLO AVENUE</b>	
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>MONTGOMERY</b>	13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. STREET ADDRESS <b>20902</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JACOB GUNOD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>EVA MASEL</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>050-18-1367</b>		17. INFORMANT <b>ROBERTA GUNOD, 11511 MONTICELLO AVENUE, SILVER SPRING, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100 Congestive Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Acute myocardial infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>19 years</b> (b) <b>Arteriosclerotic Heart Disease</b> (c) <b>19 years</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>4100</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>28 APR 1983</b> , to <b>29 APR 1983</b> , that (I) (we) last saw the deceased alive on <b>28 APR 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Ira N. Tublin</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>29 APR 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>IRA N. TUBLIN, M. D.</b>		22e. ADDRESS <b>8830 CAMERON STREET, SILVER SPRING, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>		23b. DATE <b>5/1/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>JUDEAN MEMORIAL GARDENS</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>OLNEY, MONTGOMERY, MARYLAND</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b> <b>232 CARROLL STREET, N.W., WASHINGTON, D. C.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. [Signature]</b>					

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[Faint, mostly illegible text and markings across the page, including a large 'X' or 'Z' shape in the lower left and various handwritten notes.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

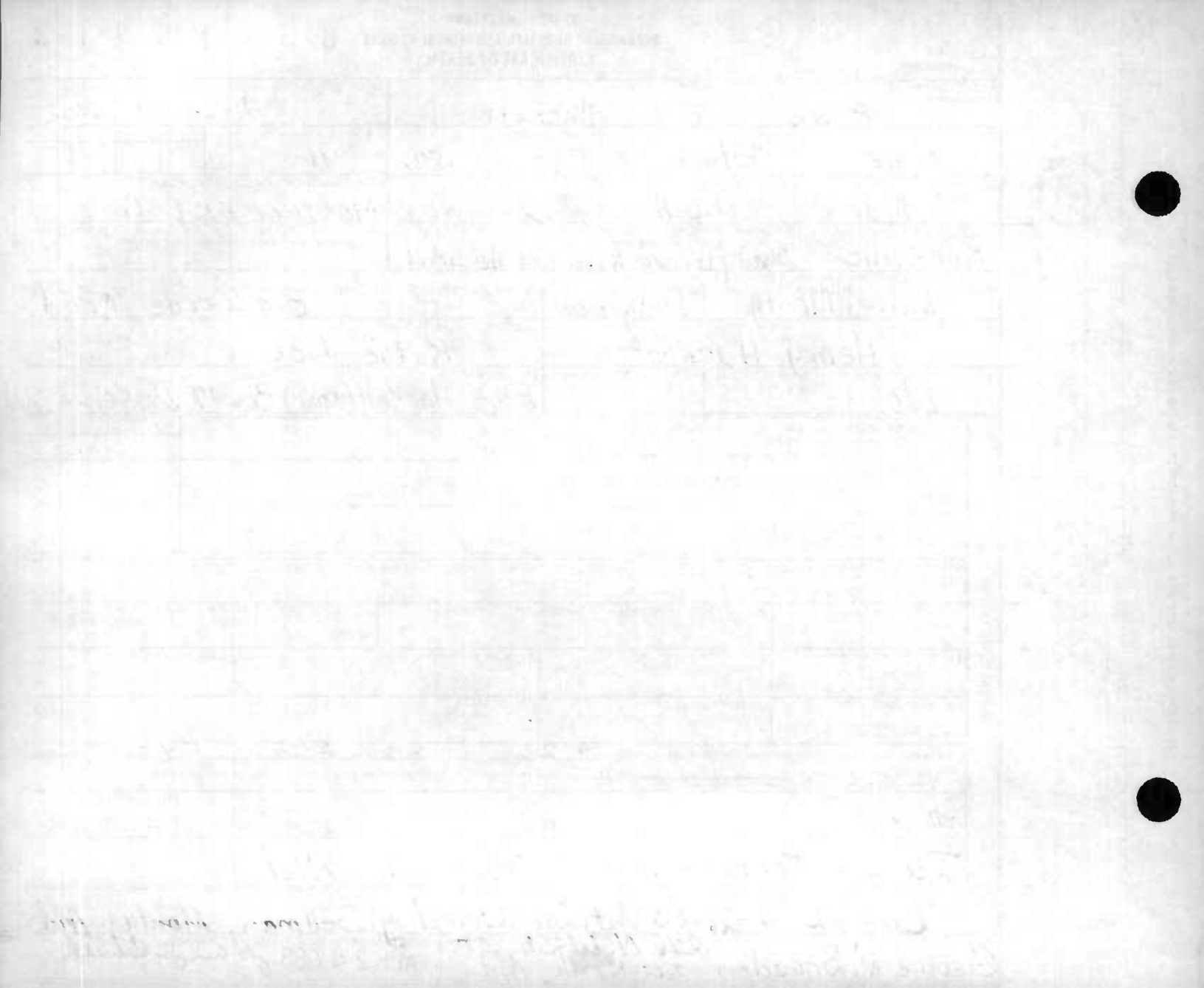
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers, Pages 1 and 2, and 7 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 9 1 2			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Elave T. Hackett</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4-23-83</b>		2b. HOUR <b>2002 M</b>	
3. SEX <b>MALE</b>		4. RACE <b>BLACK</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEB. 5, 1892</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>91</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY Co., MD.</b>	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Montg.</b>		13c. CITY OR TOWN <b>Dickerson</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Hackett</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katie Lee</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS <b>Ellis Hackett (son) Box 17, Dickerson Md</b>			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4275</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>Pan-Hypopharyngeal Duct</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-23-83</b> , to <b>4-23-83</b> , that (I) (we) lost the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Joseph A. Fortuna, M.D.</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>4.25.83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS <b>Bethesda, Md</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4-28-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (CITY OR TOWN) COUNTY STATE <b>Sellman, Montg. Md.</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>George R. Snowden 246 N. WASH. ST. Rockville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 28 1983</b>			





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 5 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Frank C. Hall								April 29, 1983								3:30 AM	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
M	W	May 17 1943		49 YRS.						April 29, 1983						3:30 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Phila., Pa.		USA						Montgomery, MD.									
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Kensington				Kensington Garden				Nice				President Finance Co.					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		10820 Georgia Ave Apt. 303									
14. FATHER'S NAME								15. MOTHER'S MAIDEN NAME									
John Hallowell								Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT									
No				184-09-6250				Mary C. Hallowell, 10820 Georgia Ave, Apt. 303, Wheaton, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 8880 IMMEDIATE CAUSE (a) <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <u>Arteriosclerotic Renal Br.</u> (c) <u>5 yrs</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: <u>1 yr.</u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Fractured Hip</u>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
4-3-83				Fracture of Hip								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 4:1 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Fell at home									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE Georgia Ave. Silver Spring Mont.-MD									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE				TITLE (SPECIFY)				MEDICAL EXAMINER				DATE SIGNED					
John Rogers, MD				Seminary Rd. Silver Spring, Md.								April 12, 1983					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE							
Removal				4-30-83		Lakeview Mem. Pk				Cinnaminson, N.J.							
24. FUNERAL DIRECTOR								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Collins F.H. 500 University Ave, Silver Spring, Md.								MAY 3 1983				John Rogers					



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 8 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 10914	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH					2b. HOUR	
FIRST MIDDLE LAST HARRY Hamburger					MONTH DAY YEAR April 26, 1983					3 P. M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		CAUS		MONTH DAY YEAR 5 24 12		70 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
NY		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring		Holy Cross Hospital				Salesman (Ret.)		Wh/se-Jute Bus.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?					
Florida		Broward		Hollywood		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
								2751 So. Ocean Drive, #1406N			
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME						
FIRST MIDDLE LAST Alexander Hamburger					FIRST MIDDLE LAST Molly Krebs						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				
Yes					WWII		060-07-5245 Mel Levinson; 8812 Copenhaver Drive; Potomac, Md (20854)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Respiratory Failure										minutes	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
(b) Nodular Mixed cell Lymphoma										14 months	
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from SEPT 19 82, to 4/26 19 83, that (I) (we) lost saw the deceased alive on 4/26 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE										22c. DATE SIGNED	
Dr. Leonard Bedno, M.D.										4/26/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)										22e. ADDRESS	
Leonard Bedno										8630 Fenton St. #230 River Spring MD 20910	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION			
Burial			4/19/83		Sharon Gdns. Mem. Park			Ft. Lauderdale; Broward; Florida			
24. FUNERAL DIRECTOR DANZANSKY-GOLDBERG MEMORIAL CHAPELS										25. DATE REC'D. BY REGISTRAR	
NAME ADDRESS 1170 Rockville Pike; Rockville, Md. 20852										MAY 2 1983 John J. Canale	

RECEIVED  
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U.S. AIR FORCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10915

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
19c. STREET ADDRESS		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE	
22a. SIGNATURE		22b. DATE SIGNED		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION



200% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8310916

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		APRIL 20 1983		10:30 P	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
FEMALE		CAUCASIAN		MONTH DAY YEAR JULY 12 1903		79 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
INDIANA		UNITED STATES				MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN-SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		NAVAL HOSPITAL		SCHOOL TEACHER		Schools	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MARYLAND		MONTGOMERY		CHEVY CHASE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e. STREET ADDRESS		13f. STREET ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		3712 STEWART DRIVE		20815	
WILLIAM FRANCIS BROOKS		ROSE ZINKIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES)		17. INFORMANT		ADDRESS	
NO		N/A		VINCENT J. HANRAHAN		3712 STEWART DRIVE,	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:		CHEVY CHASE, MD 20815		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4239 IMMEDIATE CAUSE (a) CARDIAC TAMPONADE							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF			
		(c)		DUE TO, OR AS A CONSEQUENCE OF			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from		APRIL 19 83		to		APRIL 20 19 83	
saw the deceased alive on		APRIL 20 19 83		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE		DEGREE		22c. ADDRESS		22d. DATE SIGNED	
MARION R. McMILLAN		M.D.		NATIONAL CAPITAL REGION, BETHESDA, MD 20814		22 Apr 83	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)		22f. ADDRESS		22g. LOCATION		22h. COUNTY	
MARION R. McMILLAN, LT, MC, USNR		NAVAL HOSPITAL, NAVAL MEDICAL COMMAND		Arlington		Virginia	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		4-25-1983		Arlington National		Arlington	
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		APR 26 1983		John J. Carrell	

• H •

H. K. CHOI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>LEONA ROSALIND ROBINSON HARDIE</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>4-30-83</b>					2b. HOUR <b>12 45</b> M
3. SEX <b>Female</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 18 42</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>40</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		8. IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>3 Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher &amp; Counselor/P.G.Co.</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>P.G.</b>		13c. CITY OR TOWN <b>Camp Springs</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>6713 Robinia Road</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Fletcher L. Robinson, Jr.</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leona Smith</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>225-56-4886</b>		17. INFORMANT <b>6713 Robinia Road, Camp Springs, Robert Hardie, Jr. (husband) Maryland</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1749</b> IMMEDIATE CAUSE (a) <b>Metastatic CARCINOMA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma right breast</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b> <b>5 years</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Feb. 4</b> , 19 <b>81</b> , to <b>4/30</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>4/29</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Hubert J. Alpert</b>					DEGREE <b>MD</b>			22c. DATE SIGNED <b>4/30/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HUBERT J. ALPERT, MD</b>					22e. ADDRESS <b>8630 FENTON ST. SILVER SPRING, MD 20910</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5/4/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Maryland Silver Spring, Montgomery Co.</b>			
24. FUNERAL DIRECTOR <b>LATNEY's Funeral Home</b> <b>3831 Georgia Avenue, NW, Washington, DC</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 13 1983</b>					
					25b. REGISTRAR'S SIGNATURE <b>John J. Grier</b>					

BP

RESISTANCE



CHIEF MAN  
20% COTTON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	3	1	0	9	1	8
1 - STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) <b>NELLIE CECILIA HARGETT</b>										2a. DATE OF DEATH MONTH <b>4</b> DAY <b>13</b> YEAR <b>83</b> 2b. HOUR <b>11:15 PM</b>						
3. SEX <b>FEMALE</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH <b>MARCH 31<sup>ST</sup>, 1894<sup>TH</sup></b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.			IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 74 HRS. HOURS <b></b> MIN. <b></b>		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.							
10. CITY OR TOWN OF DEATH <b>KENSINGTON</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>KENSINGTON GARDENS</b>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>EMPLOYED</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>KENSINGTON</b>			13e. STREET ADDRESS <b>2916 UNIV. BLVD. W., 20895</b>								
14. FATHER'S NAME FIRST <b>ALBERT</b> MIDDLE <b>C.</b> LAST <b>HARGETT</b>					15. MOTHER'S MAIDEN NAME FIRST <b>MAMIE</b> MIDDLE <b>P.</b> LAST <b>MCCULLOUGH</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>					16b. SOCIAL SECURITY NO. <b>216-38-5262</b>					17. INFORMANT <b>BROTHER</b> ADDRESS <b>1908 GLEN ROSS ROAD</b>						
					<b>JOHN ALBERT HARGETT</b>					<b>SILVER SPRING, MD. 20910</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> <b>4360</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b> <b>1 year</b>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Malnutrition, Psoriasis, Chronic urinary tract infection.</b>																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) this hospital attended the deceased from <b>12/13</b> , 19 <b>79</b> , to <b>4/13</b> , 19 <b>83</b> , that (1) (we) lost saw the deceased alive on <b>4/13</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>George Kenton, MD</b>										DEGREE		22c. DATE SIGNED <b>4/14/83</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>GEORGE S. KENTON, MD</b>										22e. ADDRESS <b>10620 Georgia Ave, Silver Spring, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>					23b. DATE <b>4/16/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. MARV'S CEMETERY ROCKVILLE</b>					23d. LOCATION CITY OR TOWN <b>MONT</b> COUNTY <b>MD.</b> STATE				
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>										25. DATE REC'D. BY REGISTRAR <b>APR 21 1983</b>						
<b>500 UNIV. BLVD. W., SILVER SPRING, MD. 20901</b>										26. REGISTRAR'S SIGNATURE <b>John J. Collins</b>						



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGE 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FOUR COPIES OF THIS CERTIFICATE. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1, 2, AND 4 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10919	
1. DECEASED NAME (TYPE OR PRINT) <b>Romaine Florence Harrington</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>4 10 83</b>		2b. HOUR <b>8:45am</b>			
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 13 1893</b>	6. AGE (IN YEARS) LAST BIRTHDAY YRS. <b>89</b>	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>4 10 83 19</b>		2d. HOUR <b>8:45am</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD					
10. CITY OR TOWN OF DEATH <b>Takoma Park,</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Practical Nurse</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>hospital</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>733 Sligo Avenue SS Md 20910</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Jeremiah O Harrington</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret - O'Brien</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579 44 0984</b>		17. INFORMANT <b>Nephew Joseph O. Ryan</b> ADDRESS <b>16 Parkside Rd. Silver Spring, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>4019</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 yrs.</u>									PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		
19a. DATE OF OPERATION <u>None</u>									19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>None</u>		
20a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>[Signature]</i>				TITLE (SPECIFY) M.D. <u>Dep</u>				MEDICAL EXAMINER DATE <u>April 10, 1983</u> SIGNATURE <i>[Signature]</i>			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>Apr. 13, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Holy Rood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington D.C.</b>					
24. FUNERAL DIRECTOR NAME <b>Robert A. DeVol</b>				ADDRESS <b>Home/2222 Wisconsin Ave. Washington D.C.</b>		DATE REC'D. BY REGISTRAR <b>APR 19 1983</b>		REGISTRAR'S SIGNATURE <i>[Signature]</i>			



Washington D.C. U.S.A.  
Francis Byrne

Joseph O. Ryan  
New York  
10 Madison St.  
New York, N.Y.



APR 10 1963  
Level 1000000 Ave.  
Washington D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 10920			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
JOSEPH ALPHONSE		HARTMAN, SR.						4/25		4	25	83	10 <sup>5</sup> M
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
MALE	WHITE	MONTH DAY YEAR		70		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland		U.S.A.				MONTGOMERY						MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (IF WORKING)		12b. KIND OF BUSINESS OR INDUSTRY							
TOKOMA PARK		WASHINGTON ADVENTIST HOSPITAL		PROCUREMENT OFFICER		NAVY DEPT							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
MARYLAND		MONTGOMERY		SILVER SPRING		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8708 BRADFORD ROAD				20901	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
JOHN		FLORENCE M. MILLER											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
NO		578-07-9508		Elizabeth Ann Hartman		Same as 13		WIFE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <u>Respiratory arrest</u>													
2396 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <u>Brain tumor</u>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:													
<u>carcinosis of the liver, cerebral atrophy</u>													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
		HOUR A.M. MONTH DAY YEAR											
		P.M. 19											
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION									
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		[AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.]		STREET		CITY OR TOWN		COUNTY		STATE			
AT WORK													
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>70</u> to <u>4.25</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>4.24</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED							
<u>M Snow MD</u>						4.25-83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
M SNOW MD		9013 FLOWER AVE SILVER SPRING MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION							
CREMATION		4/28/83		METROPOLITAN CREMATORY		ALEXANDRIA VIRGINIA							
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
NAME													
FRANCIS J. COLLINS		APR 28 1983		<u>John J. Smith</u>									
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901													

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 9 2 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>George ABDALLAH HASROUNI</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 14, 1983</b>		2b. HOUR <b>8:07p M</b>	
3. SEX <b>Male</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>January 18, 1947</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>36</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>LEBANON</b>		7b. CITIZEN OF WHAT COUNTRY? <b>CANADA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNTANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>M. RIIBNER CO.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. STREET ADDRESS <b>2301 Glenallen #814</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE YOUSSEF HASROUNI</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MALAKEH FARAH</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>			
16b. SOCIAL SECURITY NO. <b>213-02-5314</b>		17. INFORMANT <b>MOUSSA HASROUNI</b>		ADDRESS <b>4641 12th ST LAVA W. QUEBEC, CANADA</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Pericarditis, Severe</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Probable Myocarditis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Pericardial Effusion</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>5770</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>APR 14</b> 19 <b>83</b> to <b>APR 14</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>APR 14</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Joel Schelman</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/15/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Joel Schelman</b>		22e. ADDRESS <b>9410 Old Georgetown Rd</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4-18-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING, MONTG. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>W. W. CHAMBERS CO. INC.</b>		ADDRESS <b>SILVER SPRING Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 20 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. G... ..</b>	



STIVER SPRING  
MONTGOMERY STIVER SPRING  
JULY CROSS HOSPITAL  
MONTGOMERY  
JANUARY 18 1945  
APRIL 17 1945  
INSTRUMENT

STIVER SPRING  
MONTGOMERY STIVER SPRING  
JULY CROSS HOSPITAL  
MONTGOMERY  
JANUARY 18 1945  
APRIL 17 1945  
INSTRUMENT

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10922

REG. NO.

FOR  
1. STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Myhodeen Hatun</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 19, 1983</b>			2b. HOUR <b>11:45AM</b>			
3. SEX <b>Male</b>		4. RACE <b>East Indian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 10 1907</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>75</b>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>YRS.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Guyana</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Guyana</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Grocery Business</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>14417 Jaystone Dr. 20904</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Hatun</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>unobtainable</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>N/A</b>		17. INFORMANT ADDRESS <b>Jamalodee Baksh-son-(same as 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>klebsiella pneumonia</b> <b>4820</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/18</b> 19 <b>83</b> , to <b>4/19</b> 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>4/18</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death.)									
22b. SIGNATURE <b>Mark Rosen</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/19/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Mark Rosen, MD</b>			22e. ADDRESS <b>Silver Spring, Md.</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Apr. 24, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Georgetown Guyana</b>		
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>			11800 N.H. Ave., ADDRESS <b>Silver Spring, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>APR 20 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Mary Glassford Hausrath</b>									
2a. DATE OF DEATH MONTH DAY YEAR <b>4-3-83</b>		2b. HOUR <b>4:51a M</b>							
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1-8-98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b>		7. IF UNDER 1 YEAR MONTHS DATES <b>YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>COLORADO</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTEGOMERY MD.</b>			
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MD</b>		13b. COUNTY <b>MON T.</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>120 HILLTOP ROAD</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>JESSIE C. GLASSFORD</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>THUSA TUPPER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>214-48-8343</b>		17. INFORMANT ADDRESS <b>ALFRED H. HAUSRATH - 120 HILLTOP RD, SS.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). <b>Coronary Arteriosclerosis</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b). <b>Advanced ASVD and acute MI.</b> DUE TO, OR AS A CONSEQUENCE OF (c). <b>and aortic aneurysm</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <b>1980</b> , 19 <b>4-3</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>March 19, 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Charles L. Franklin Jr</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4/3/1983</b>	
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>CREMATION</b>		23b. DATE <b>April 4, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore MD</b>			
24. FUNERAL DIRECTOR NAME <b>Takoma Funeral Home, J. J. Williams</b>		ADDRESS <b>251 Carroll St. NW</b>		25a. DATE OF REGISTRATION BY REGISTRAR <b>APR 6 1983</b>					

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TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

DHMH - 16 50M 4/82  
(VRA 15, 4)

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 10924			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Margaret M. Hayes</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 18 83</b>		2b. HOUR <b>3:30AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>AUG 3, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOMEMAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b>				13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>SILVER SPRING</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>ALBERT HEATHCOCK</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MAUDE MARY GAUDIN</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>226-38-9191</b>		17. INFORMANT <b>DAUGHTER 4200 MARK ROAD</b> <b>JACQUELINE M. CANNON SPARTA, N.J. 07871</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: <b>4360</b> IMMEDIATE CAUSE (a) <b>C.V.A.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>4/17/83</b> , 19 <b>83</b> , to <b>4/18/83</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>4/17/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/18/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALLAN B. COHAN</b>				22e. ADDRESS <b>13975 CONN AVE., SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>4/19/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>		23d. LOCATION CITY OR TOWN COUNTY <b>ALEXANDRIA VIRGINIA</b>	
24. FUNERAL DIRECTOR <b>FRANCIS J. COLLINS</b> NAME ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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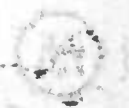
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APR 21 1944

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the Registrar, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 3 1 0 9 2 5						
1. FOR STATE REGISTRAR					CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
Thomas R. Hazlett					April		7		83		11		05 M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male		Caucasian		January 4, 1916		67 YRS.		MONTHS		DAYS		HOURS MIN.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH										
Pennsylvania		United States				Montgomery County MD										
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		Suburban Hospital								Owner/Floor Supply Co.						
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			Zip: 20814		
Maryland					Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9408 Corsica Drive					
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME											
Thomas Hazlett					Mary Patterson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT									
Yes					WWII		190-09-9634		Same as #13 Mrs. Irene D. Hazlett, Wife							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
IMMEDIATE CAUSE (a) 1951 Cerebrovascular accident										48 hours						
DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Metastases										3 wks						
DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma (colorectal)										1 yr						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																
None																
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 2 Apr 1983 to 7 Apr 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED						
22b. SIGNATURE Paul T. Noone										8 Apr 83						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS											
Paul T. Noone, M.D.					50 W. Edmonston Dr., Rockville, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial					11, 1983		Gate of Heaven Cemetery, Silver Spring, MD									
24. FUNERAL DIRECTOR NAME					25a. DATE REC'D. BY REGISTRAR					25b. REGISTRAR'S SIGNATURE						
Robert A. Pumphrey					APR 13 1983					John J. Smith						
Homes, P.A., Bethesda, Maryland																

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OFFICE OF THE  
ATTORNEY GENERAL  
STATE OF TEXAS



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by Dr. Mayle/4/27/83 rlb

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		83		10926		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <i>Thomas R Healand</i>					2a. DATE OF DEATH MONTH <i>4</i> / DAY <i>27</i> / YEAR <i>83</i> 2b. HOUR <i>4:14 AM</i>				
3. SEX <i>Male</i>		4. RACE <i>Caucasian</i>		5. DATE OF BIRTH MONTH <i>August</i> / DAY <i>31</i> / YEAR <i>1934</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>48</i> YES <input type="checkbox"/> NO <input type="checkbox"/>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Massachusetts</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery</i> MD.			
10. CITY OR TOWN OF DEATH <i>Rockville</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Shady Grove Adventist Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>computer operat</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Govt.</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Gaithersburg</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>807 Frederick Ave. (20877)</i>	
14. FATHER'S NAME FIRST <i>Patrick</i> MIDDLE <i>J.</i> LAST <i>Healand</i>					15. MOTHER'S MAIDEN NAME FIRST <i>Gertrude</i> MIDDLE <i>South</i> LAST <i>Nickerson</i>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. <i>012-26-7915</i>		17. INFORMANT ADDRESS <i>Harriet L. Healand (Wife) 807 Frederick Ave. Gaithersburg, Maryland 20877</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <i>4149</i> IMMEDIATE CAUSE (a) <i>Cardiogenic shock</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Artery Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 hrs</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a <i>Hypertension / Ectopy</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/27</i> , 19 <i>83</i> , to <i>4/27</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>4/27</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dennis Friedman</i>		DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>4/27/83</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>DENNIS FRIEDMAN</i>		22e. ADDRESS <i>13-15 E DEER PARK DR. GAITHERSBURG MD</i>							
23a. BURIAL, CREMATION, REMOVAL SPECIFY <i>Burial</i>		23b. DATE <i>4/30/1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Forest Oak Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Gaithersburg, Montgomery, Md.</i>			
24. FUNERAL DIRECTOR <i>Robert A. Pumphrey Funeral Homes, P.A. 300 W. Montgomery Ave., Rockville, Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAY 2 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

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4/24/82

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Carnegie Library

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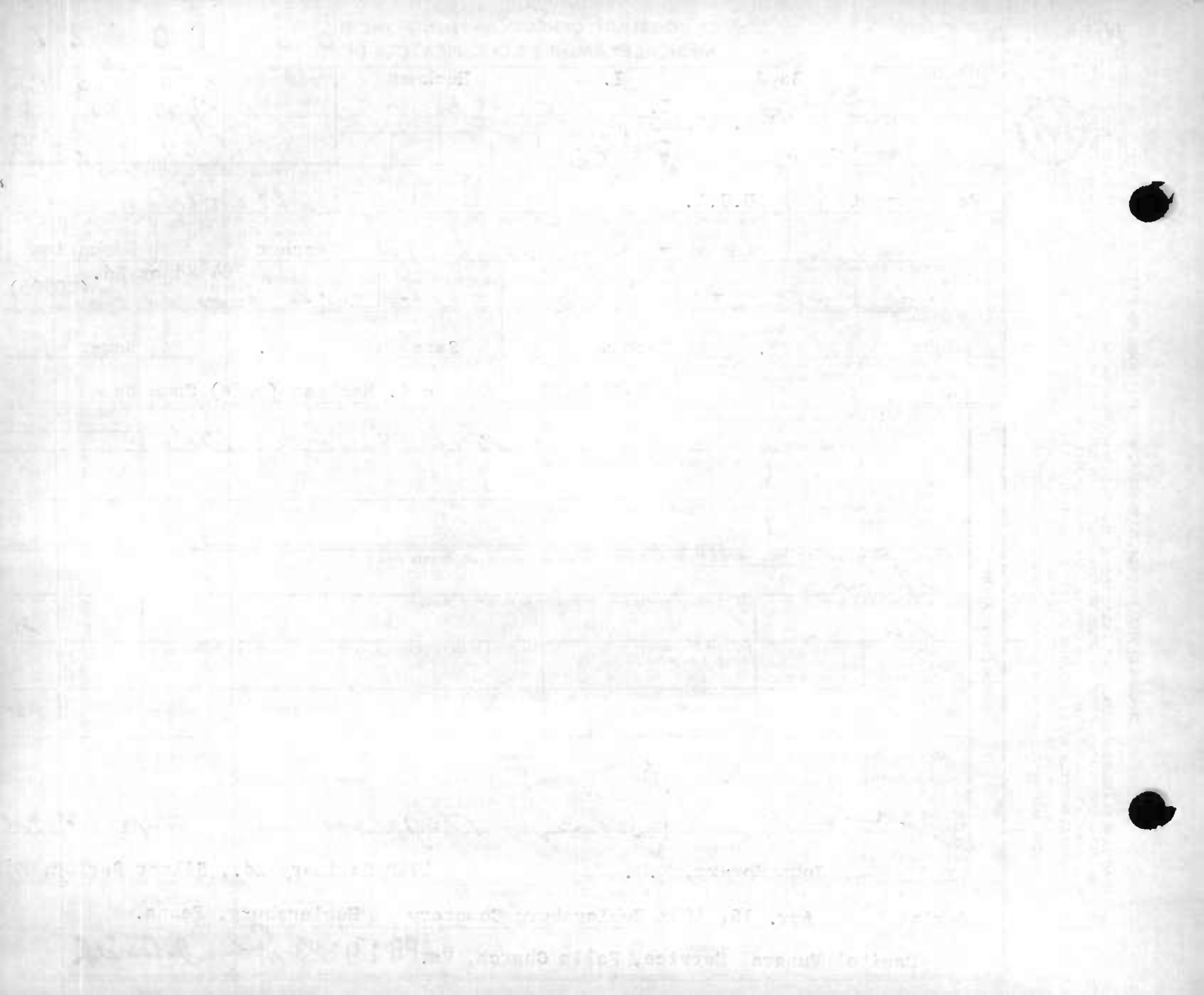
4/24/82

12-12 E. Green St. Dr. [illegible]

12-12 E. Green St. Dr. [illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10927	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <b>Boyd I. Heckman</b>										2a. DATE KNOWN OF DEATH ESTIMATED <b>April 12, 1937</b>	
2. SEX <b>Male</b> 3. RACE <b>White</b> 4. AGE (IN YEARS LAST BIRTHDAY) <b>46</b> YRS. 5. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. 6. DATE PRONOUNCED DEAD <b>April 13, 1937</b>										7. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b> 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>	
10. CITY OR TOWN OF DEATH <b>Olney</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mont. General Hosp.</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>											
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b> 13b. COUNTY <b>Mont.</b> 13c. CITY OR TOWN <b>P.O. Spg.</b> 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS <b>704 Ednor Rd. (20905)</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>John E. Heckman</b> 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sara B. Bower</b>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. <b>172-30-2170</b> 17. INFORMANT ADDRESS <b>Eunice A. Heckman (wife) Same as 13</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4291 Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Due to, or as a consequence of</b> (c) <b>Due to, or as a consequence of</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>											
19a. DATE OF OPERATION <b>None</b> 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b> 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b> 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <b>John Rogers, M.D.</b> TITLE (SPECIFY) <b>M.D.</b> MEDICAL EXAMINER DATE SIGNED <b>April 14, 1937</b>											
EXAMINER'S NAME (TYPE OR PRINT) <b>John Rogers, M.D.</b> ADDRESS <b>1919 Seminary Rd., Silver Spring, Md</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>Apr. 16, 1937</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Hublersburg Cemetery</b> 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hublersburg, Penna.</b>											
24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Service, Falls Church, Va.</b> ADDRESS <b>APR 19 1937</b> 25a. DATE REC'D. BY REGISTRAR <b>John J. Canfield</b> 25b. REGISTRAR'S SIGNATURE											



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10928

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Katherine Janet Hedges</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4/12/83</i>			2b. HOUR A M <i>1:30 A</i>					
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>AUG. 31. 1949</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>33</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>WASHINGTON, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>MONTGOMERY</i> MD.					
10. CITY OR TOWN OF DEATH <i>TAKOMA PARK</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>WASHINGTON ADVENTIST HOSPITAL</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>HOMEMAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13a. STREET ADDRESS <i>7207 WILLOW AVENUE</i>			13b. CITY OR TOWN <i>20912</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>ALBERT MARSELLAS</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>NOT AVAILABLE</i>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>				16b. SOCIAL SECURITY NO.	
17. INFORMANT ADDRESS <i>DIANE Z. HEDGES, SILVER SPRING MD</i>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Insufficiency</i> <i>1519</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Stomach Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 months</i>				PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1; OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from <i>15 JAN 1983</i> to <i>12 April 1983</i> and that (2) (we) last saw the deceased on <i>11 April 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (where) (at) (did not view the body after death).										23c. DATE SIGNED <i>4/12/83</i>	
22b. SIGNATURE <i>Thomas A. Bensinger</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			23e. DATE SIGNED <i>4/12/83</i>		
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>THOMAS A. BENNINGER</i>			22d. ADDRESS <i>7676 NEW HAMPSHIRE AVE LANGLEY PARK MD</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>April 15, 1983</i>		23c. NAME OF CEMETERY OR CREMATORY <i>George Washington Cemetery</i>			23d. LOCATION CITY OR TOWN COUNTY <i>Adelphi 20703 MD</i>			
24. FUNERAL DIRECTOR <i>J. Edgar Deller</i>			24a. ADDRESS <i>254 Carroll St. N. W. D. C.</i>			24b. DATE <i>APR 14 1983</i>			24c. REGISTRAR'S SIGNATURE <i>John J. Connel</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

10

RECEIVED  
JUL 12 1952  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK (100-158711)  
SUBJECT: JAMES EARL RAY, AKA  
RE: NEW YORK TELETYPE TO BUREAU, JULY 11, 1952.  
ENCLOSED FOR THE BUREAU ARE TWO COPIES OF A  
LETTERHEAD FROM THE NEW YORK OFFICE DATED JULY 11, 1952,  
AND TWO COPIES OF A LETTER FROM THE NEW YORK OFFICE  
DATED JULY 11, 1952, TO THE NEW YORK OFFICE.  
THE NEW YORK OFFICE IS REQUESTING THAT THE BUREAU  
ADVISE THE NEW YORK OFFICE OF ANY DEVELOPMENTS  
WHICH MAY BE OF INTEREST TO THE NEW YORK OFFICE.  
VERY TRULY YOURS,  
J. Edgar Hoover  
DIRECTOR

100-158711

RECORDED  
INDEXED  
JUL 12 1952  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10929

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Marjorie R HEIN			2a. DATE OF DEATH MONTH DAY YEAR APRIL 26, 1983		2b. HOUR 10:26 AM						
3. SEX female		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 6 23 19		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WISCONSIN		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH WHEATON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 6 FOXHALL COURT				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADM. ASSISTANT		12b. KIND OF BUSINESS OR INDUSTRY U.S. HOUSE OF REPRESENTS.			
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3500 FOREST EDGE DRIVE 20906		
14. FATHER'S NAME FIRST MIDDLE LAST ROBERT G. HEIN			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDITH E. CARTER								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 398-01-4498		17. INFORMANT SISTER CAROL CARNAHAN		ADDRESS 6 FOXHALL COURT WHEATON, MD. 20906				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a) METASTATIC OVARIAN CARCINOMA DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 MONTHS											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from JUNE 19 82, to APRIL 26, 19 83, that (I) (we) last saw the deceased alive on APRIL 19, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eugene P. Flannery MD			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4.26.83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY, M.D.			22e. ADDRESS 18111 Prince Philip Drive OLNEY, Md. 20832								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 4/29/83		23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN			23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR MAY 2 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

RECEIVED  
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DIRECTOR OF THE  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item #5 Film G579 5/23/83 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 3 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>VIRGIL MARKLEY HEISTAND</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 27 1983</b>			2b. HOUR a.m. <b>3:00</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>FEBRUARY 2 1918</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) <b>INDIANA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b>			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S.A.F.</b>	
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>BETHESDA</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6310 HERKOS COURT</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM JAY HEISTAND</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>RUTH ELEANOR CUNNINGHAM</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1936-1964</b>		17. INFORMANT ADDRESS <b>LOUISE A. HEISTAND, 6310 HERKOS COURT,</b>					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BETHESDA, MD 20817</b> <b>METASTATIC ADENOCARCINOMA OF THE COLON</b> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

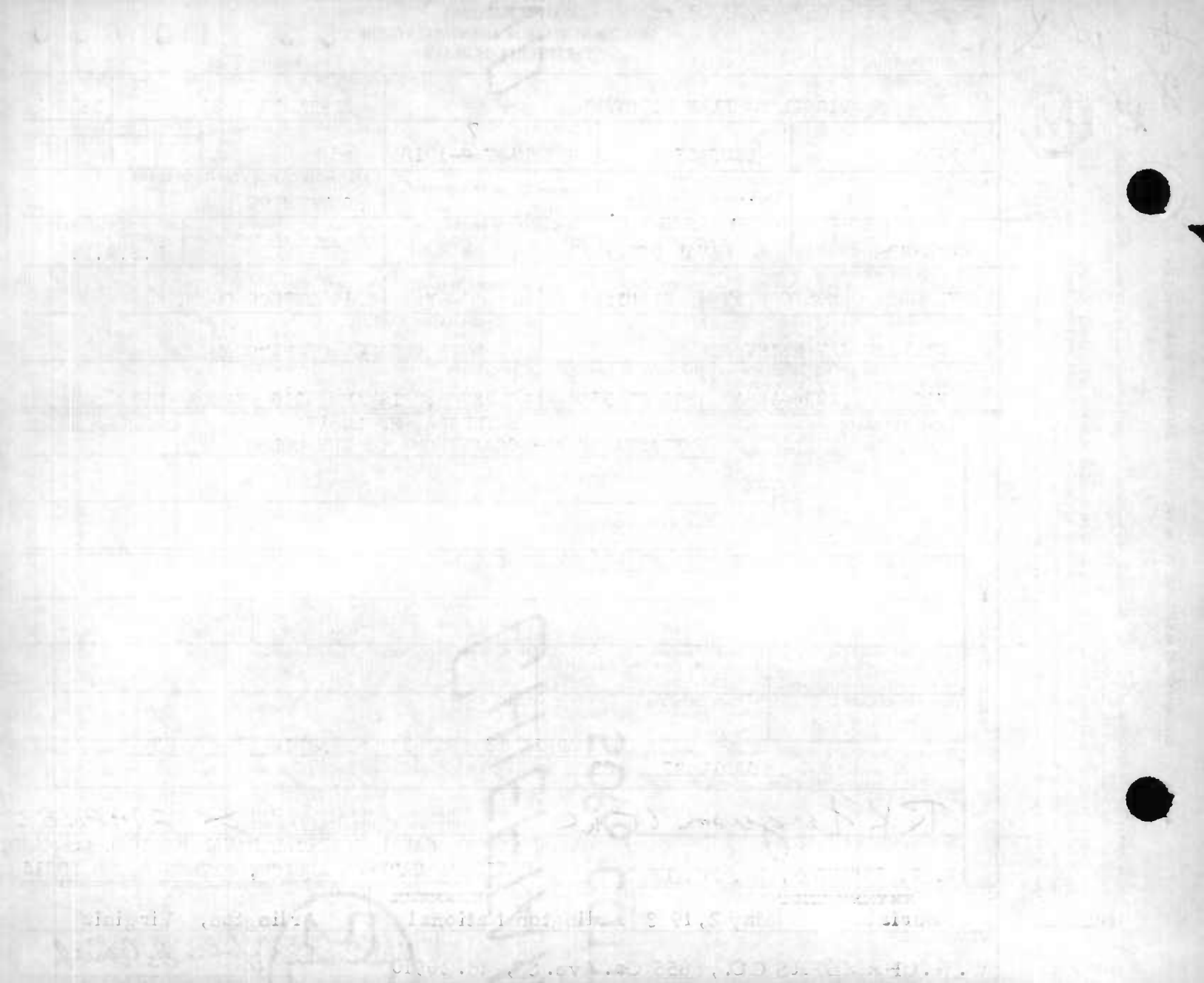
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from **APRIL 13**, 19**83**, to **APRIL 27**, 19**83**, that (I) (we) lost  
saw the deceased alive on **APRIL 27**, 19**83**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <b>R. K. Ferguson, LT, MC</b>		DEGREE		22c. DATE SIGNED <b>27 APR 83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. K. FERGUSON, LT, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			

23a. BURIAL, CREMATION, REINTERMENT (SPECIFY) <b>Burial</b>		23b. DATE <b>May 2, 1983</b>		23c. NAME OF CEMETERY OR CREMATOR <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>	
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24. FUNERAL DIRECTOR NAME <b>W. W. CHAMBERS CO., 8655 Ga. Ave. SS, Md. 20910</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR <b>MAY 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. (IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 10931	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Margaret L. Helbert</b>				2a. DATE OF DEATH. MONTH DAY YEAR <b>4 24 83</b>	
3. SEX <b>Female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>5 14 1910</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b>		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		8. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>		10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>		12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12c. KIND OF BUSINESS OR INDUSTRY <b>home</b>	
13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John H. Poole</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maggie Crown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>	
17. INFORMANT <b>Eugene E. Helbert same as 13c</b>		18. SOCIAL SECURITY NO. <b>216-05-1022</b>		19. ADDRESS <b>804 Gail Avenue 20851</b>	
20. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>4100 Cardio-respiratory Arrest</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b>	
DUE TO, OR AS A CONSEQUENCE OF (a) <b>7 Arteriosclerotic Coronary Disease</b>				8 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Thrombosis</b>				4 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Cerebral Fatty Degeneration - Organic Brain Syndrome</b>					
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>4/23/83</b> to <b>4/24/83</b> , that (I) (we) lost saw the deceased alive on <b>4/23/83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Stephen N. Jones</b>		22c. ADDRESS <b>809 Viers Mill Rd. Rockville, Md. 20851</b>		22d. DATE SIGNED <b>4/24/83</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/26/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park Rockville, Maryland</b>	
23d. LOCATION (CITY OR TOWN) <b>Rockville, Maryland</b>		23e. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park Rockville, Maryland</b>		23f. LOCATION (CITY OR TOWN) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home, Inc.</b>		24a. ADDRESS <b>1331 Rockville Pike Rockville, Maryland 20852</b>		24b. DATE RECD BY REGISTRAR <b>APR 27 1983</b>	
24c. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		24d. REGISTRAR'S SIGNATURE <b>John J. Carver</b>		24e. REGISTRAR'S SIGNATURE <b>John J. Carver</b>	

BP



BOX COTTON

CHILFEN



APR 3 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 0 9 3 2	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Mary Elizabeth Henderson</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>April 10 1983</i>		2b. HOUR <i>11:00 AM</i>			
3 SEX <i>F</i>		4 RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Oct. 1 04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>78</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN) <i>WASHINGTON, D.C.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery MD.</i>					
10. CITY OR TOWN OF DEATH <i>Silver Spg.</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1215 Luzerne Ave</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>SUPPLY TECH</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>W.R.A.M.C.</i>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <i>MD</i>		13b. COUNTY <i>Montgomery</i>		13c. CITY OR TOWN <i>Silver Spg.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>1915 Luzerne Ave</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>DUNCAN</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>JULIA</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>							
16b. SOCIAL SECURITY NO. <i>217-32-3017</i>		17. INFORMANT <i>TRUST OFFICER</i> ADDRESS <i>SUBURBAN BANK TRUST 6610 ROCKLEDGE DRIVE BETHESDA, MD. 20817</i>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i> <i>4291</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>											
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from <i>March 19 79</i> to <i>April 10 1983</i> that (I) (we) last saw the deceased alive on <i>April 6 1983</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
23a. SIGNATURE OF PHYSICIAN'S NAME (TYPE OR PRINT) <i>John S. Rogers</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		23c. DATE SIGNED <i>April 10 1983</i>			
23b. ADDRESS <i>1919 SEMINARY ROAD, SILVER SPRING, MD.</i>											
23d. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23e. DATE <i>4/15/83</i>		23f. NAME OF CEMETERY OR CREMATORY <i>CEDAR HILL CEMETERY</i>		23g. LOCATION CITY OR TOWN COUNTY STATE <i>SUITLAND PRT GEO MD.</i>					
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i>						25a. DATE RECEIVED BY REGISTRAR <i>APR 21 1983</i>		25b. REGISTRAR'S SIGNATURE <i>John J. Collins</i>			
26. FUNERAL HOME ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 9 3 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>GABRIELLA L HENNEBERGER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4-21-83</b>		2b. HOUR <b>5:30 A M</b>	
3 SEX <b>FEMALE</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>7-24-90</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>9-2</b> YRS. MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY County, MD.</b>	
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARRIAGE HILL 9101 2ND AVE S-SMD</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>NURSE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Health Care</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE <b>M.D.</b> 13c. COUNTY <b>MONT</b> 13d. CITY OR TOWN <b>Silver Spr</b> 13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13f. STREET ADDRESS <b>9101 2nd Avenue</b> Zip: <b>20910</b>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>John LASSALL</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Gertrude Cecilia ANDERSON</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b> (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO. <b>577-30-7491</b> 17 INFORMANT <b>Josiah Henneberger</b> ADDRESS <b>224 BETTY LEWIS DR. FREDERICKS HUNG VA</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Erosive gastritis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hiatal Hernia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4/83</b> <b>1980</b> <b>1990</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>CHF, Abdominal aortic aneurysm CAD</b>							
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <b>4/83</b> , 19 <b>80</b> , to <b>4/21/83</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>4/83</b> , 19 <b>83</b> , and that in (2) <b>4/21/83</b> a physician death occurred on the date and hour and from the causes stated above. (1) <b>4/83</b> (2) <b>4/21/83</b>							
22b. SIGNATURE <b>MBP Patrick III MD</b> DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-21-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MB Patrick III MD</b>				22e. ADDRESS <b>9221 Colesville Rd Silver Spring, Md 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 25, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>	
24 FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>				24b. ADDRESS <b>Homes, P.A., Bethesda, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 2-1983</b> 25b. REGISTRAR'S SIGNATURE <b>John E. Coughlin</b>	

BP



(M)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please use carbon papers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

DHMH-16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3

1 0 9 3 4

REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>SADIE HERSHY.</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-10-83</b>			2b. HOUR - <b>6:45</b> AM				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 18, 1889</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Hungary</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.				
10 CITY OR TOWN OF DEATH <b>ROCKVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Hebrew Home of Greater Washington</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14 FATHER'S NAME FIRST MIDDLE LAST <b>Johann Bergida</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Liebe Middleman</b>			13e. STREET ADDRESS <b>6121 Montrose Road</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b SOCIAL SECURITY NO. <b>054-18-7706J1</b>		17 INFORMANT ADDRESS <b>Rockville, Md.</b>				17b. ADDRESS <b>Frances Robbins; 15401 Short Ridge Court</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY <b>4860 IMMEDIATE CAUSE (a) Cardiorespiratory failure.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>76 months</b>		
DUE TO, OR AS A CONSEQUENCE OF <b>Obdumb type unknown</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <b>Dementia, severe, arteriosclerotic heart disease.</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <del>the</del> (this hospital) attended the deceased from <b>12-7-</b> 19 <b>73</b> , to <b>4-10</b> 19 <b>83</b> , that <del>we</del> (we) lost saw the deceased alive on <b>4-10</b> 19 <b>83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I <del>do</del> did not) view the body after death.										
22b. SIGNATURE <b>K. H. SHAH</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		17c. DATE SIGNED <b>4/10/83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>K. H. SHAH MD</b>			22e. ADDRESS <b>6121 MONTROSE RD. ROCKVILLE</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>4-11-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Riverside Cemetery Rochelle Park, New Jersey</b>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>			Rockville, Md.			APR 10 1983		REGISTRAR'S SIGNATURE <b>Sam J. G...</b>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified orally.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10935

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE LYLE HERZER			2a. DATE OF DEATH MONTH DAY YEAR 4 22 83			2b. HOUR 3:45 PM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR July 17 1903		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Iowa		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Person		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD			13b. COUNTY MONT		13c. CITY OR TOWN SILVER SPRING		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1405 DUBLIN DRIVE 20902		
14. FATHER'S NAME FIRST MIDDLE LAST Cero			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Tanbace								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 484-22-3042		17. INFORMANT ADDRESS Rey. Kenneth H. Hodge 3005 Airport Blvd.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Histiocytoma of gallbladder with met</u> 2169 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Recurrent GI bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 83</u> to <u>4/22/83</u> , 19 <u>83</u> , that (I) <del>was</del> last saw the deceased alive on <u>4/22</u> , 19 <u>83</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did not) view the body after death.											
22b. SIGNATURE <u>Smith S. Ho, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/23/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SMITH S. HO, M.D.			22e. ADDRESS 8323 Haddon Dr Takoma Pk Md 20912								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial.			23b. DATE Apr. 26, 1983			23c. NAME OF CEMETERY OR CREMATORY Columbia Gardens, Arlington, Va.			23d. LOCATION CITY OR TOWN COUNTY STATE		
24a. FUNERAL DIRECTOR <u>Takoma Funeral Home, Inc.</u>			24b. ADDRESS 254 Carroll St. N. W. D. C.			25a. DATE REC'D. BY REGISTRAR APR 27 1983			25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>		



... .. LIBRARY

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (1))

20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Calvin Bernard Hill			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 4 23 1983			2b. HOUR M 2:40P					
3. SEX Male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR May 23, 1954	6. AGE (IN YEARS) LAST BIRTHDAY 28 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4 23 1983			7d. HOUR M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.			13b. COUNTY Montg.		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1104 Good Hope Drive 20904	
14. FATHER'S NAME FIRST MIDDLE LAST James C. Hill				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Powell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS James C. Hill (father) Brighton, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of head (handgun)</u> 9550 Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> . (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR MONTH DAY YEAR 4 23 1983 P.M.			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1104 Good Hope Dr., Silver Spring, Mont., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>			TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER						DATE SIGNED 4/24/83		
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.			ADDRESS 111 Penn St. Balto., MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 4-29-83		23c. NAME OF CEMETERY OR CREMATORY Bush Park Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Cookeville, Howard, Md.			
24. FUNERAL DIRECTOR George R. Snowden			246 N. Washington St. Rockville, Md. 20850			25a. DATE REGD. BY REGISTRAR APR 28 1983					

MEMORANDUM FOR THE DIRECTOR

RE: [Illegible]



OLIVIA STEER

10/10/44





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 10937	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Ethel M. Himes</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>April 14, 1983</b>				2b. HOUR <b>7:45AM</b>		
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 12, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>					
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Maryland</b>					13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS <b>(20853) 13403 Turkey Branch Pkwy.</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Raulin</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Bonsal</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>					16b. SOCIAL SECURITY NO. <b>577-18-0922</b>		17. INFORMANT ADDRESS <b>Robert S. Himes, same as #13</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4310</b> IMMEDIATE CAUSE (a) <b>Cerebral aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral hemorrhage</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>3/10/83</b>										APPROPRIATE INTERVAL BETWEEN DEATH AND DEATH <b>4/14/83</b> <b>3/10/83</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Asymptomatic pneumonia, renal failure, hypertension</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPOST? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (the hospital) attended the deceased from <b>3/10</b> , 19 <b>83</b> , to <b>4/14</b> , 19 <b>83</b> , that (1) (the) lost saw the deceased alive on <b>4/13</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (the) (do not) view the body after death.											
22b. SIGNATURE <b>Arthur Schoengold</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/14/83</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Arthur Schoengold, M.D.</b>		22e. ADDRESS <b>18101 Pinner Place A Silver Spring, Maryland 20832</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 16, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cem.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumfrey</b>		24b. ADDRESS <b>Homes, P.A. Rockville, Maryland 20850</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canale</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1 - FOR STATE REGISTRAR					REG. NO. 83 10938					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dr. S. Ralph Himmelhoch					2a. DATE OF DEATH MONTH DAY YEAR 4.21.83.			2b. HOUR 4:15 M		
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR November 11, 1935		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 47		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Michigan		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Physician			12b. KIND OF BUSINESS OR INDUSTRY Medical		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland					13c. COUNTY Montgomery		13d. CITY OR TOWN Rockville		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Akiba Joseph Himmelhoch					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah J. Simmons					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1962-1964		17. INFORMANT Joan Z. Himmelhoch		ADDRESS 6412 Danville Ct. Rockville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 5150 IMMEDIATE CAUSE (a) SEVERE HYPOXEMIA, PROGRESSIVE DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY FIBROSIS, IDIOPATHIC DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS YEARS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a NONE										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (GIVE NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 19 81 to 4/ 83, that (I) (we) lost saw the deceased alive on 4/21 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE OF PHYSICIAN Edward S. Mehlman, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 4/21/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EDWARD S. MEHLMAN					22e. ADDRESS 5625 BRADLEY BOULEVARD BETHESDA, MARYLAND					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April 22, 83		23c. NAME OF CEMETERY OR CREMATORY Lee Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Washington D.C.				
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Mem. Chapels					ADDRESS 1170 Rockville Pike Rockville, Md.					

DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE

APR 25 1983

John J. Carver



APPENDIX  
J. G. G. G.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				83 10939			
1. FOR STATE REGISTRAR				REG. NO.			
I. DECEASED NAME (TYPE OR PRINT) <b>JOHN CARVER HOLIBAUGH</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4-19-83</b>		2b. HOUR <b>9:30 A.M.</b>	
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 30, 1930</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Biloxi, Miss.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>4715 Falcon Street</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Administrative Mgr. IBM</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS <b>4715 Falcon Street</b>		13f. ZIP CODE <b>20853</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Carver Holibaugh</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Albertine Weiss</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>Korea</b>		17. INFORMANT ADDRESS <b>4715 Falcon Street</b> <b>Enid G. Holibaugh, Wife, Rockville, Md. 20853</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>HEMORRHAGIC SHOCK</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>MINUTES</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>WIDELY METASTATIC CANCER.</b> <b>4 MO.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>BRONCHIOGENIC ADENOCARCINOMA</b> <b>8 MO.</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>AUG 1</b> , 19 <b>82</b> , to <b>APR 19</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>APR 14</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Richard P. Delaney MD</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>Apr. 19, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RICHARD P. DELANEY MD</b>				22e. ADDRESS <b>4323 HARVARD ST. SILVER SPRING MD 20916</b>			
23a. METHOD OF CREMATION, BURIAL, OR OTHER DISPOSITION (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 20, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P. G. Cty., Md.</b>	
24. FUNERAL DIRECTOR NAME <b>W. W. CHAMBERS CO., 8655 Ga. Ave. SS, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 21 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: See how requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Martha Jane Horner			2a. DATE OF DEATH MONTH DAY YEAR 4 28 83		2b. HOUR 10 P.M.
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 7 1911		6. AGE (IN YEARS LAST BIRTHDAY) 71	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOW IN SUCH FACILITY, GIVE STREET ADDRESS) Fairland Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) never employed			12b. KIND OF BUSINESS OR INDUSTRY --		
13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spr.
14. FATHER'S NAME FIRST MIDDLE LAST Andrew A. Horner			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Bruce Morrison		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 20903 Andrew A. Horner-Brother-(same as 13c)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary embolus</u> 4151 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Down's syndrome, Rheumatoid arthritis, Osteoarthritis</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>9/29</u> , 19 <u>71</u> , to <u>4/28</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>2/28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>George S. Kenton, MD</u>		DEGREE		22c. DATE SIGNED 4/29/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>GEORGE S. KENTON, MD</u>		22e. ADDRESS <u>10620 GEORGIA AVE, SILVER SPRING, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-2-1983		23c. NAME OF CEMETERY OR CREMATORY Presbyterian Cemetery	
24. FUNERAL DIRECTOR Name Hines/Rinaldi Funeral Home		ADDRESS 11800 N.H. Ave. Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR MAY 3 1983	
				25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	

Cleared by Medical Examiner



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HONOLULU, HAWAII

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 4 1

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Charles C. Hsia</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 28 83</b>			2b. HOUR <b>12:48AM</b>				
3. SEX <b>Male</b>		4. RACE <b>Chinese</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 13, 1912</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70</b>		7. IF UNDER 1 YEAR MONTHS DAYS <b>YRS</b>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>China</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.				
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Civil Eng. Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov't.</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>15210 ElkrIDGE Way Apt. 2.B.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-66-0292</b>		17. INFORMANT ADDRESS <b>1135 Betts Trailway, Potomac, Md. 20854.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchogenic Carcinoma left lung</b> <b>1629</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo</b>										
PART II: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Liver Hypocalcemia, Congestive heart failure, Lymphangitic metastases @ lung, metastases</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART II)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 27</b> , 19 <b>83</b> , to <b>Apr 28</b> , 19 <b>83</b> , that (I) <del>was</del> <b>live</b> saw the deceased alive on <b>Apr 27</b> , 19 <b>83</b> , and that in (my) <del>own</del> <b>live</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>was</del> <b>live</b> (did not) view the body after death.										
22b. SIGNATURE <b>Donald E. Dillon</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>28 Apr 83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DONALD E. DILLON, M.D.</b>				22e. ADDRESS <b>18111 PRINCE PHILIP DR. OLNEY, MD.</b>						
23a. MANNER OF CREMATION, BURIAL, OR OTHER DISPOSITION (SPECIFY) <b>Cremation</b>			23b. DATE <b>Apr. 29, 1983</b>		23c. NAME OF PLACE OF CREMATION <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P. G. Cty., Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>W.W. CHAMBERS CO., 8655 Ga., Ave., SS, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove contents of pages 1 and 2 and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or other disposition of the body. The medical examiner must be notified of any important: if item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of any

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ada FLORENCE Humphrey			2a. DATE OF DEATH MONTH DAY YEAR 04 13 83			2b. HOUR 3:26 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Feb. 15, 1880		6. AGE (IN YEARS LAST BIRTHDAY) 103 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H. Wife	
12b. KIND OF BUSINESS OR INDUSTRY Home		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 20832		13b. COUNTY Mont.		13c. CITY OR TOWN Olney	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 17220 Georgia Ave.		13f. CITY OR TOWN Georgia		13g. STATE Ga.	
14. FATHER'S NAME FIRST MIDDLE LAST William - Rector				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Susan - (Unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 226-86-2474		17. INFORMANT ADDRESS Marie A. Yeardley Same as #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Bleeding</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Lactic Acidosis</u>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>April 12, 1983</u> to <u>April 13, 1983</u> , that (I) (we) last saw the deceased alive on <u>April 12, 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Barry Heels</u>		22c. DATE SIGNED 4/13/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BARRY HEELS		22e. ADDRESS 3929 FERRARA DRIVE WHEATON, MD 20906	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr. 15, 1983	
23c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church Fairfax Va.	
24. FUNERAL DIRECTOR Francis H. Barber Laytonsville, Md. 20879		25a. DATE REC'D. BY REGISTRAR APR 18 1983	
25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>		25c. REGISTRAR'S SIGNATURE	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or entombment.

IMPORTANT: If item 21 is marked off, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO. 8310943				
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>ROCHELLE Hurwitz</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>4-8-83</b>			2b. HOUR <b>5<sup>15</sup> A</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 9 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS <b>81</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Roumania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co. MD.</b>			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Colonial Villa Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Home maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. CITY OR TOWN <b>Md Montgomery Silver Spring</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>12325 New Hampshire Ave 20904</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max Segal</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rebecca UNK</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>NONE</b>		17. INFORMANT ADDRESS <b>Mrs Bess Shay (Daughter) 909 Crest Park Silver Spring Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac failure</b> <b>4289</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>March 19 83</b> to <b>April 8 19 83</b> that (I) (we) lost saw the deceased alive on <b>4-3 19 83</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <b>S.B. Cusner, MD</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-8-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>S.B. CUSNER, MD</b>			22e. ADDRESS <b>1161 New Hampshire Ave, Sil. Spr.</b>						
23a. BURIAL, CREMATION, REMOVAL <b>CREMATION</b>			23b. DATE <b>4-9-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>W.W. Chambers</b>			ADDRESS <b>8655 Georgia Ave Silver Spring Md</b>		25a. DATE REC'D BY REGISTRAR REGISTRAR'S SIGNATURE <b>APR 12 1983 John J. Carney</b>				

MEDICAL CERTIFICATION

W. J. ...  
N.S.A.

Colonel ...  
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 4 4  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Arthur C IDdings</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 1st 1983 8:00 PM</b>		
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 24, 1928</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		7b. HOUR <b>8:00 PM</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ILLINOIS</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>		
10. CITY OR TOWN OF DEATH <b>Bethesda</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>COMMERCIAL ARTIST</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MARYLAND</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>SILVER SPRING</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>HARRY G. IDdings</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>FLORA VanANTWERP</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>KOREAN 317-20-8995</b>	17. INFORMANT <b>BROTHER ADDRESS 5942 EAST CABALLO LANE SCOTTSDALE, ARIZONA 85253</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>MULTIPLE BRAIN ABSCESSSES</b> <b>2028</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>NON-HODGKINS LYMPHOMA OF SPINAL CORD ~3 mos</b> (c) <b>PNEUMONIA</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>~ ONE WEEK</b> <b>~ ONE WEEK</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a <b>STERIOD MYOPATHY, HYDROCEPHALUS, CEREBRAL EDEMA</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from <b>MARCH 23, 1983</b> , to <b>APRIL 1, 1983</b> , that (1) (we) lost saw the deceased alive on <b>April 1, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (have) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Dal Yoo</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAL YOO, M.D.</b>		22e. ADDRESS <b>1140 VARNUM ST. NE. WASH. DC 20017</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>CREMATION</b>		23b. DATE <b>4/4/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>METROPOLITAN CREMATORY</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>ALEXANDRIA VIRGINIA</b>					
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR <b>APR 8 1983</b>	



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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		83 10945 REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
AIMA		K.		I		HRIG		4-29-83		10 55 AM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Female.		White.		MARCH 13. 1906		77					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Chicago, Ill.		U. S. A.				Montgomery, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
WHEATON		University Nursing Home.						Nurse.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
MD		MONTGOMERY		TAKOMA PARK				7520 MAPLE AVENUE 20412			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Gustav Kott.				Augusta Parel							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				352-10-1665		Florence Campbell. 7520 Maple Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC Arrest											
4292											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										DUE TO, OR AS A CONSEQUENCE OF (b) Arterio sclerotic cardiovascular disease	
										DUE TO, OR AS A CONSEQUENCE OF (c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from JAN 7, 19 82, to present, 19 83, that (I) (we) last saw the deceased alive on 25 April 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE		22c. DATE SIGNED			
WALTER Goetz						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		1/29/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
WALTER Goetz											
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial.				MAY 2. 1983		Ft. Lincoln		Bladensburg Rd. P. G. Md.			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Walter Walters				254 Carroll St. N. W. Takoma Funeral Home.				MAY 2 1983 John J. Connel			

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WEEK OF 1936  
AT 11, 1936

University of Illinois

Chicago, Ill.

August 11, 1936

353-10-1-62 A Florence Campbell, 1720 Maple Ave.

Chicago, Ill.  
August 11, 1936

Wm. J. 1936, 1720 Lincoln, Chicago, Ill.  
353-10-1-62 A Florence Campbell, 1720 Maple Ave.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8310946

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT NAME) <b>Elizabeth Catherine Jackson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 29, 1983</b>			2b. HOUR P. <b>11:45</b> M.			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 16, 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>California</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Teacher</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nyack College</b>	
13a. STATE <b>New York</b>		13b. COUNTY <b>Rockland</b>		13c. CITY OR TOWN <b>Upper Nyack</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>204 Glenbrook Road 10960</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Frank Garlock</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Mickelson</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>079-34-7322</b>		17. INFORMANT ADDRESS <b>505 Bradford Dr. Rockville, Maryland 20850</b> <b>Dr. Barbara A. Underwood - Foster Daughter</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>1991 Metastatic Carcinoma</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>One year</b>	
IMMEDIATE CAUSE (a) <b>1991</b>		DUE TO, OR AS A CONSEQUENCE OF (b)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (c)	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>April 4, 1983</b> to <b>April 29, 1983</b> , that (I) (we) last saw the deceased alive on <b>April 26, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) not view the body after death.							
22b. SIGNATURE <b>B. Arumini M.D.</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4-30-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>B. Arumini M.D.</b>				22e. ADDRESS <b>3770 Vermont Ave. NW, Wash. D.C. 20007</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>May 5, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Nyack Rockland N.Y.</b>	
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b> ADDRESS <b>500 University Blvd, W. Silver Spring, Maryland</b>				25a. DATE REC'D. BY REGISTRAR <b>MAY 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>F. J. Collins</b>	

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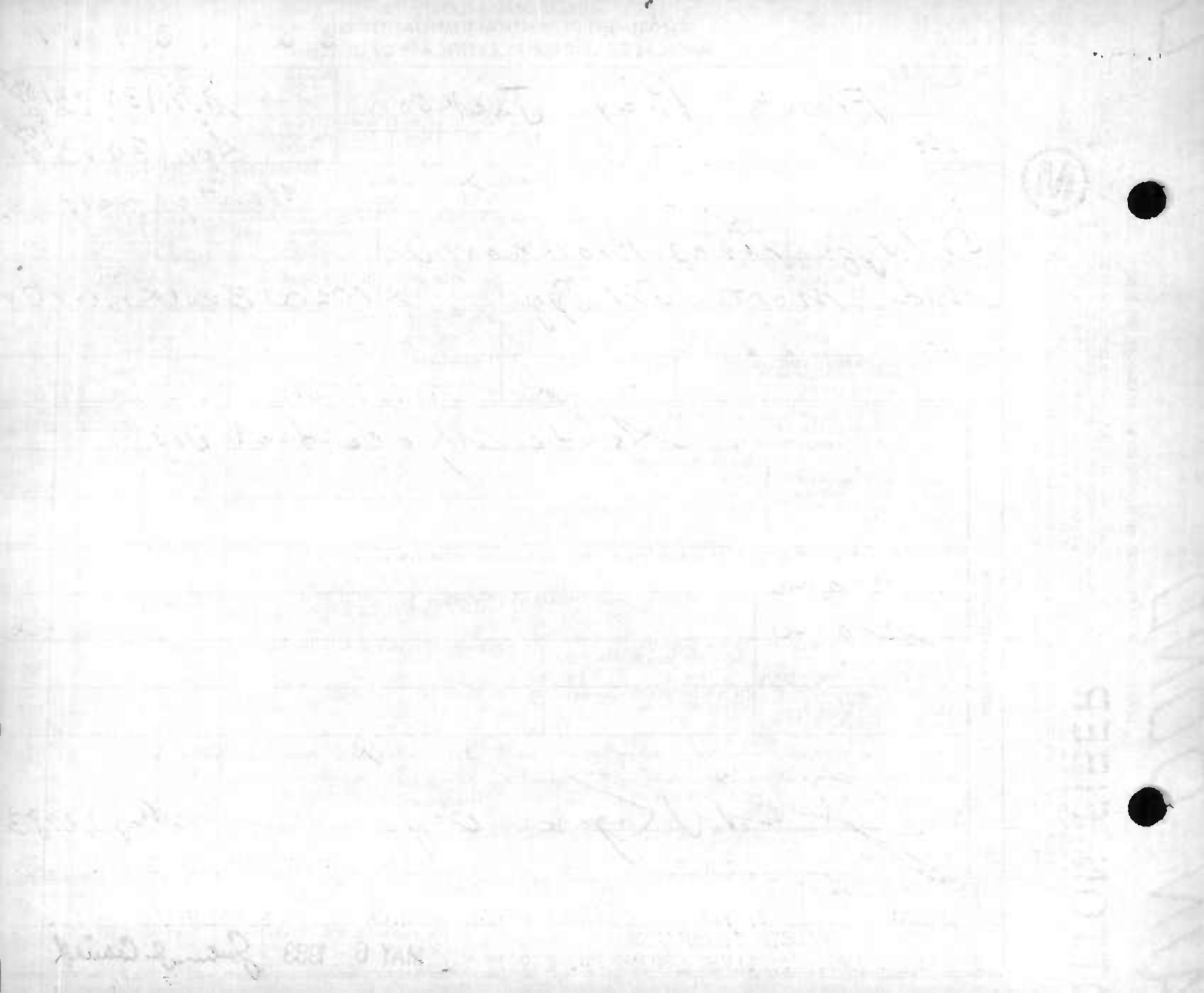
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8310947	
1. DECEASED NAME (TYPE OR PRINT) <b>Frank Ray Jackson</b>						2a. DATE KNOWN OF DEATH MONTH DAY YEAR <b>April 13, 1983</b>		2b. HOUR OF DEATH MIN. <b>8:30</b>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>April 13, 1983</b>	
3. SEX <b>M</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>OCT 4, 1930</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>52</b> YRS.	7. UNDER 1 YR. MONTHS DAYS HOURS MIN.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD.</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>WASHINGTON, D. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>10203 Brookmar Dr.</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>BUILDER</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>SELF EMPLOYED</b>		13a. STATE <b>MD</b>		13b. COUNTY <b>Montg</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>10203 Brookmar Dr</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>FRANK W. JACKSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CARLOTTA A. BIBER</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>				16b. SOCIAL SECURITY NO. <b>WW II 218-24-6993</b>		17. INFORMANT ADDRESS <b>BETTY J. JACKSON SAME AS 13 WIFE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4291 Acute Myocardial Dis.</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>None</b>						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 2b PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>		TITLE (SPECIFY) <b>M.D. Dep.</b>						DATE SIGNED <b>May 1, 1983</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>		ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>5/4/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EMMANUEL UNITED METH. CH.</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>SCAGGSVILLE MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 6 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			
26. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 9 4 8	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>BABY GIRL JOHNS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>MARCH 16, 1983</b>		2b. HOUR <b>4:34pm</b>
3. SEX <b>FEMALE</b>	4. RACE <b>BLACK</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>March 16, 1983</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>2</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONT.</b> MD.	
10. CITY OR TOWN OF DEATH <b>TAKOMA PARK</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WASHINGTON ADVENTIST</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>N/a</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>
13a. STATE <b>MD</b>	13b. COUNTY <b>MONT.</b>	13c. CITY OR TOWN <b>TAKOMA PARK</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS <b>1102 Linden Ave. #2</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Duckett</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Avis Vanessa Johns</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>N/A</b>		17. INFORMANT ADDRESS <b>MOTHERS MEDICAL RECORD CHART</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>7650 IMMEDIATE CAUSE (a) Immaturity &lt; 20 wks. gestation</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Herminia Zarzuela</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>5-15-83</b>	
22d. PHYSICIAN'S SIGNATURE <b>Narong Suvannasankha</b>		22e. ADDRESS <b>7600 Carroll Ave. T-akoma Park, MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>3-16-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Washington Adventist</b>	
23d. LOCATION <b>Takoma Park Mont. Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Herbert Z. Shiroma</b>		ADDRESS <b>7600 Carroll Ave. T.P. MD</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 23 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Connelley</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 475-1234.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 9 4 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Martha M. Johnson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 22, 1983</b> 2b. HOUR <b>2:08 P.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 15 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>77</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13a. COUNTY <b>Montgomery</b> 13a. CITY OR TOWN <b>Silver Spring</b>				13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS <b>11451 Lockwood Dr. 20904</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>(unobtainable) King</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Susan (unobtainable)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) <b>N/A</b>		17. INFORMANT <b>Stanley R. (son), Jr. 5784 Steven Forest Rd. Columbia, Md. 21045</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4100 IMMEDIATE CAUSE (a) Acute Myocardial Infarction</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary Atherosclerosis</b>							<b>years</b>
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arterio sclerotic Cardiovascular disease</b>							<b>years</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Multiple Myeloma; Adenocarcinoma of Breast</b>							
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 25 1983</b> to <b>4/22 1983</b> , that (I) (two) last saw the deceased alive on <b>4/22 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>G. Leonard Gold, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/22/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Leonard Gold, MD.</b>				22e. ADDRESS <b>8630 Fenton St., S.S. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-25-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, DC</b>	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>		ADDRESS <b>11800 N.H. Ave., Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 26 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 10950	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mildred (NMN) Johnson						2a. DATE OF DEATH MONTH DAY YEAR April 3, 1983			2b. HOUR A M 4:15		
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR October 25 1946		6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH Clinical Center, Bethesda, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Police Officer		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DC				13b. COUNTY Washington		13c. CITY OR TOWN Washington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2407 Naylor Rd, SE 20020	
14. FATHER'S NAME FIRST MIDDLE LAST Horse Eagle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Wilcher							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 578-60-5904		17. INFORMANT ADDRESS Mr. William Johnson (husband) same as pt.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FIBROSIS AND CONSOLIDATION (ALL LOBES)</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>THROMBOCYTOPENIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>MITRAL AND AORTIC VALVE VEGETATIONS</u> <u>SYSTEMIC LUPUS ERYTHEMATOUS AND RENAL FAILURE</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH WEEKS WEEK WEEKS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>March 7</u> , 19 <u>83</u> , to <u>April 3</u> , 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <u>April 3</u> , 19 <u>83</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.											
22b. SIGNATURE <u>Frederick P. Cgnibene, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 4/3/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Frederick P. Cgnibene, M.D.				22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE April 8, 1983		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery Brentwood, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Stewart Funeral Home-4001 Benning Rd. N.E.				25a. DATE REC'D. BY REGISTRAR APR 6 1983				25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

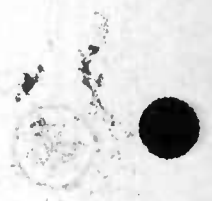
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the registrars after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					83 10951	
FOR Item 4 4-25-83 cn 1. STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Susie J Johnson				2a. DATE OF DEATH MONTH DAY YEAR 04 17 83		2b. HOUR 1235 <sup>MPa</sup>
3. SEX F	4. RACE C White	5. DATE OF BIRTH MONTH DAY YEAR 6 24 13		6. AGE (IN YEARS LAST BIRTHDAY) 69	7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? US	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWER <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Rockville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY Bakery		
13a. STATE Md.		13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS Vandergrift Ave. 20851	
14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Carrie Davidson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If YES, GIVE BRANCH OR DATES) No		16b. SOCIAL SECURITY NO. 411-46-0777		17. INFORMANT Address 564H Rockville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>Small cell carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>2 years</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>immediate</u>						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Chronic obstructive lung disease</u>						
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>4/16</u> , 19 <u>83</u> , to <u>4/17</u> , 19 <u>83</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>4/17</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.						
22b. SIGNATURE <u>Michael A. Greene</u>		DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>4/17/83</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael A. Greene, MD</u>		22e. ADDRESS <u>19271 Montgomery, Virginia</u>				
23a. BURIAL, CREMATION, REMOVAL SPECIES <u>Burial</u>		23b. DATE <u>4-20-83</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mahanaim Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Clinchburg, Virginia</u>
24. FUNERAL DIRECTOR NAME <u>Ives Funeral Home</u>		ADDRESS <u>Arlington, Va 22201</u>		25a. DATE REC'D. BY REGISTRAR <u>APR 22 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 10952	
1. STATE REGISTRAR		REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR	
Kimmon Jones				April 19, 1983	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR	
Male		Black		May 12, 1914	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		6. AGE (IN YEARS LAST BIRTHDAY)	
North Carolina		U.S.A.		68	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		9. BALTIMORE CITY OR COUNTY OF DEATH	
Olney		Montgomery General Hospital		Montgomery County MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?	
Md.		Montg.		Gaithersburg	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		13d. STREET ADDRESS	
Dave Jones		Rebecca Smith		20908 Zion Road 20879	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
Yes		WW II		214-03-8054 Catherine V. Jones (wife) same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4149 IMMEDIATE CAUSE (a) Coronary artery disease					1 wk
DUE TO, OR AS A CONSEQUENCE OF (b)					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Possible femoral pulmonary embolus. Diabetes mellitus.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 19 75 to 19 83, that (I) (we) last saw the deceased alive on 19 Apr 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
Donald E. Dillon		M.D.		19 Apr 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Donald E. Dillon, M.D.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4-23-83		Daisy Church Cemetery	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR	
George R. Snowden		246 N. Washington St. Rockville, Md. 20850		APR 22 1983	
				REGISTRAR'S SIGNATURE	
				John J. Casper	

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Approved by Dr. Francis C. Mayle, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and coroner, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

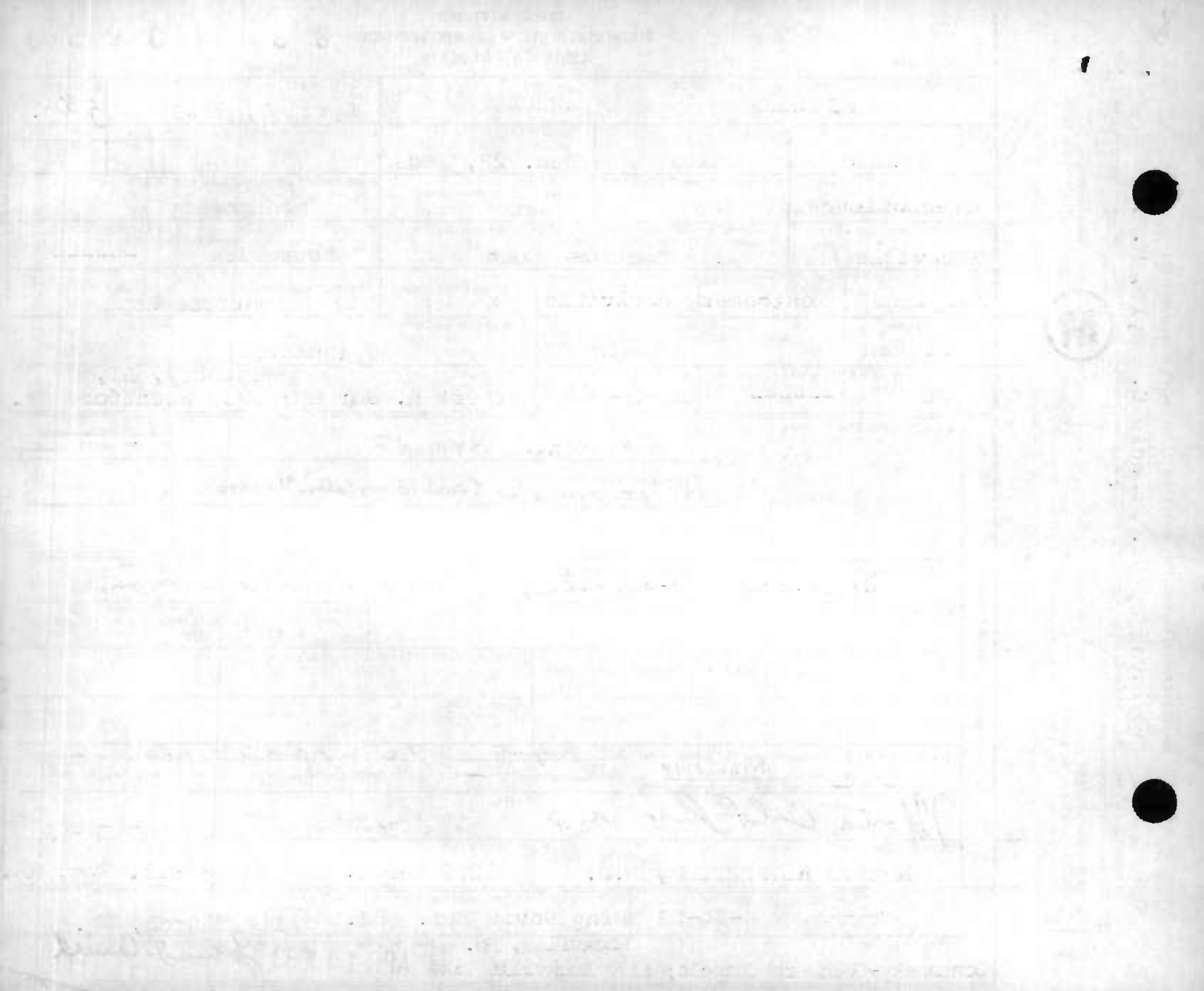
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REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
MILDRED		April 7, 1983		5:30 p.m.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	Dec. 28, 1903	79 YRS.	Montgomery MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Czechoslovakia	USA		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Rockville	6111 Montrose Road	Housewife	-----		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland	Montgomery	Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	6111 Montrose Road	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		
Herman	(unknown)		053-18-9420		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT			
No	053-18-9420	Herbert H. Jordan; 1955 Stratford Dr.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (d) <u>Cardiac Arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Cardiovascular Disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 minutes</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): <u>Diabetes Mellitus, Coronary Arteriosclerosis</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>76</u> , to <u>April</u> , 19 <u>83</u> , that <del>we</del> (we) lost saw the deceased alive on <u>March 18</u> , 19 <u>83</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, <del>that</del> (we) <del>did not</del> view the body after death.					
22b. SIGNATURE <u>Morton Altshuler, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-8-1983	
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS			
MORTON ALTSCHULER, M.D.		1299 Lamberton Drive; Sil. Spg, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	4-10-83	King David Mem. Gdn.	Falls Church, Va.		
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Danzansky-Goldberg Chapels; 1170 Rockville Pike		APR 11 1983		<u>John J. [Signature]</u>	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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REG. NO.

FOR  
1 - STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>WILLIAM F. JOYCE, Jr.</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4 11 83</b>		2b. HOUR <b>10:50 AM</b>	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>June 4, 1926</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>56</b>		7. BIRTHPLACE (STATE OR FOREIGN) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.			
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>SUBURBAN HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Contractor</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b>		13a. STREET ADDRESS <b>9510 50th Avenue</b>		13b. CITY AND ZIP CODE <b>20740</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William F. Joyce, Sr.</b>		15. MOTHER'S MAIDEN NAME MIDDLE LAST <b>Edith E. Lippard</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>	
16b. SOCIAL SECURITY NO. <b>577-30-0487</b>		17. INFORMANT NAME ADDRESS <b>Helen M. Joyce (Wife) Same as #13</b>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4275 IMMEDIATE CAUSE (a) Cardiovascular Collapse</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cardiac Dysrhythmia</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs 48 hrs</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>Cerebral Anoxia Organic Brain Syndrome Diabetes</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>1973</b> , 19 <b>83</b> , to <b>April 11</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>April 10</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. Stewart Scott, M.D.</b>		22c. ADDRESS <b>10401 Old Georgetown Rd. Bethesda, Md.</b>		22d. DATE SIGNED <b>4/11/83</b>	
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>4/14/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>	
23d. LOCATION <b>Brentwood P.G. County Maryland</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland</b>			
25a. DATE REC'D. BY REGISTRAR <b>APR 18 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

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CHIEF

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 9 5 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>John J KACKINSKY</u>				2a. DATE OF DEATH MONTH DAY YEAR 4 6 83			
3. SEX <u>MALE</u>				2b. HOUR 0718 M			
4. RACE <u>CAUC</u>		5. DATE OF BIRTH MONTH DAY YEAR 4 11 44		6. AGE (IN YEARS LAST BIRTHDAY) 38 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Ohio</u>		7b. CITIZEN OF WHAT COUNTRY? <u>United States</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery</u> MD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Teacher</u>			
10. CITY OR TOWN OF DEATH <u>Bethesda</u>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Suburban Hospital</u>			
12b. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <u>Maryland</u> 13b. CITY OR TOWN <u>Washington</u>				13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>John C. Kacvinsky</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Mary Bednar</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES <u>No</u>				16b. SOCIAL SECURITY NO. <u>284-40-0712</u>			
17. INFORMANT ADDRESS <u>Mary B. Kacvinsky 2762 Windpoint Poland, Ohio Trail</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4416</u> IMMEDIATE CAUSE (a) <u>intracranial hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ruptured aneurysm of aorta</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>abdominal aortic aneurysm</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <u>familial polyposis of colon</u>							
19a. DATE OF OPERATION <u>4/5/83</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>hemorrhage</u>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>4/5/83</u> to <u>4/6/83</u> , that (I) (we) lost saw the deceased alive on <u>4/5/83</u> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE <u>Sidney J. Malawer</u> DEGREE				22c. DATE SIGNED <u>4/6/83</u>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Sidney J. Malawer, M.D.</u>				22f. ADDRESS <u>10215 Fernwood Road Bethesda, Maryland 20817</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>April 9, 1983</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Youngstown, Ohio</u>	
24. FUNERAL DIRECTOR <u>Robert A. Pumfrey Funeral Homes, P.A. Bethesda, Maryland 20814</u>				25a. DATE REC'D. BY REGISTRAR <u>APR 15 1983</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10956

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Irena A Kamantauskas		2a. DATE OF DEATH MONTH DAY YEAR 4-13-83		2b. HOUR 5:55 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 12 04		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Lithuania	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife	12b. KIND OF BUSINESS OR INDUSTRY own home
13a. STATE Maryland		13b. COUNTY Montgomery	13c. CITY OR TOWN Wheaton	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Bernard Eimaitis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Casimira Becker		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT ADDRESS Victor Kamantauskas-son-(same as 13e)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arrhythmia 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Unstable angina Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) Coronary artery disease				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 1 month 10 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE
22a. I certify that (I) <del>did not</del> attended the deceased from Sept. 13, 1976, to 4/12, 1983, that (I) <del>did not</del> lost saw the deceased alive on above, (I) <del>did not</del> view the body after death.				
22b. SIGNATURE Hubert J. Alpert		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/13/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT J. ALPERT, MD		22e. ADDRESS 8630 FELTON ST. SILVER SPRING, MD. 20910		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 4-15-1983	23c. NAME OF CEMETERY OR CREMATORY St. George Catholic		23d. LOCATION CITY OR TOWN COUNTY STATE Norwood Mass.
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		25. DATE REC'D. BY REGISTRAR APR 14 1983

UNITED STATES

RECEIVED

1902

RECEIVED



*[Handwritten signature]*

RECEIVED

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					83 10957	
1- FOR STATE REGISTRAR			REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARY T KANAGY</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-4-1983</b>		2b. HOUR <b>6.50 A.M.</b>	
3. SEX <b>Female</b>	4 RACE <b>white</b>	5 DATE OF BIRTH MONTH DAY YEAR <b>Feb 18 1910</b>	6 AGE (IN YEARS LAST BIRTHDAY) <b>73</b> YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Fla.</b>	9b CITIZEN OF WHAT COUNTRY? <b>USA</b>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10 CITY OR TOWN OF DEATH <b>Silver Spring</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <b>Md. Montg. Sil. Spr.</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>20910 8505 Springvale Rd.</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Dean Tompkins</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Massey</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>220-26-4716</b>		17 INFORMANT ADDRESS <b>Michael T. Kanagy-26101 Rudale Dr. Clarksburg, Md. 20871</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cardiogenic shock</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiomyopathy</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>5 years</b>						
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Chronic obstructive pulmonary disease</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (1) (this hospital) attended the deceased from <b>JUNE 19 62</b> to <b>4/4 19 83</b> , that (1) (we) last saw the deceased alive on <b>4/3 19 83</b> , and that in (my/our) opinion death occurred on the date and hour and from the causes stated above. (we) (did) (did not) view the body after death.						
22b. SIGNATURE <b>James R. Coleman M.D.</b>		DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>4-4-83</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES R. COLEMAN</b>		22e. ADDRESS <b>9241 COLUMBIA BLVD SILVER SPRING MD. 20910</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>burial</b>		23b. DATE <b>4/7/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Brentwood, Pr. Geo., MD</b>
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b>		25b. REGISTRAR'S SIGNATURE <b>J. Canine</b>
ADDRESS <b>48434 Ga. Ave. silver Spring, Md.</b>						



Caribbean Bank  
Caribbean Bank

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JAMES H. COLEMAN

April 1991



STATE OF MARYLAND		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		8310958	
FOR STATE REGISTRAR		CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Frank Edmund Kaplan		April 21, 1983		9:10 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Male	White	Sept. 18, 1921	61	Montgomery MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Yugoslavia	USA		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Takoma Park	Washington Adventist Hospital	Body repairman	A.C.I. Inc.		
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Montgomery	Burtonsville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3020 Maple Hill Road 20866	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?	
Frank Kaplan		Louise Beufuss		N/A	
17. INFORMANT		18. SOCIAL SECURITY NO.		19. ADDRESS	
Freda Kaplan-wife-(same as 13e)		578-46-7130			
20. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART 1: DEATH WAS CAUSED BY:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1579 IMMEDIATE CAUSE (a): Hepatic Failure				2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.				4 months	
(b): Metastatic Pancreatic Cancer					
(c):					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:					
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21e. TIME OF INJURY		21f. HOW INJURY OCCURRED	
		HOUR A.M. MONTH DAY YEAR		(ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
		P.M. 19			
21g. INJURY OCCURRED		21h. PLACE OF INJURY		21i. LOCATION	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		CITY OR TOWN COUNTY STATE	
22. I certify that (If this hospital) attended the deceased from 20 Dec 82 to 21 April 83, that (If (we) lost saw the deceased alive on 21 April 83, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above (If (we) did not view the body after death.					
22a. SIGNATURE		22b. DEGREE		22c. DESIGNATED	
Thomas A. Bensinger		MD		4/22/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. LOCATION	
Thomas A. Bensinger		2676 New Hampshire Ave		Burtonsville Montgomery Md.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4-23-1983		Union Cemetery	
23d. FUNERAL DIRECTOR		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Hines/Rinaldi Funeral Home		11800 N.H. Ave., Silver Spring, Md.		APR 26 1983 John J. Conner	



Report of the  
Board of Directors

James P. Thompson  
President of the Board  
and the Board of Directors

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 9 5 9	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Regina E. Kaufman</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 29 83</b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>1 24 03</b>	
6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>		7. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		8. AGE (IN YEARS LAST BIRTHDAY) <b>80</b>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	
12. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Randolph Hills N.H.</b>		14. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co. MD.</b>	
15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 15a. STATE <b>MD.</b>		16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. COUNTY <b>PR. George</b>		17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. CITY OR TOWN <b>HYATTSVILLE</b>	
18. FATHER'S NAME FIRST MIDDLE LAST <b>JAMES XXXXXXXXXXXX COMBS</b>		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>GENEVIEVE EIK</b>		20. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		22. SOCIAL SECURITY NO. <b>579-42-3927</b>		23. INFORMANT SON <b>JAMES D. KAUFMAN</b>	
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4292</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>Atherosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Heart Failure</b>		25. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>		26. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CONTRIBUTING TO DEATH</b>	
27a. DATE OF OPERATION		27b. CONDITION FOR WHICH OPERATION WAS PERFORMED		28a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
29a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
30a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		30b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		30c. LOCATION STREET CITY OR TOWN COUNTY STATE <b>3720 Farmington Ave. N.W. Md. 20715</b>	
31a. I certify that (1) (this hospital) attended the deceased from <b>Feb 23 1983</b> to <b>Apr 29 83</b> , that (we) last saw the deceased alive on <b>March 19 83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (2) (we) (did) (did not) view the body after death.		31b. SIGNATURE <b>Regina E. Kaufman</b>		31c. DATE SIGNED <b>4-29-83</b>	
32a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Regina E. Kaufman MD</b>		32b. ADDRESS <b>3720 Farmington Ave. N.W. Md. 20715</b>		32c. DATE SIGNED <b>4-29-83</b>	
33a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		33b. DATE <b>5/3/83</b>		33c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>	
34a. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		34b. ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>		34c. DATE OF DEATH BY REGISTRAR <b>MAY 6 1983</b>	
35a. REGISTRAR'S SIGNATURE <b>John J. Collins</b>		35b. REGISTRAR'S SIGNATURE <b>John J. Collins</b>		35c. REGISTRAR'S SIGNATURE <b>John J. Collins</b>	

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STANDARD  
PAPER CO.



MADE IN U.S.A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 0 9 6 0	
1- FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JAMES LOWELL KELLER			2a. DATE OF DEATH MONTH DAY YEAR APRIL 4 1983		2b. HOUR 10:50 P M
3. SEX MALE	4. RACE CAUCASIAN	5. DATE OF BIRTH MONTH DAY YEAR JULY 24 1933		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OHIO	7b. CITIZEN OF WHAT COUNTRY? UNITED STATES	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD	
10. CITY OR TOWN OF DEATH BETHESDA	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NAVAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY U.S.M.C.
13a. STATE VIRGINIA		13b. COUNTY FAIRFAX	13c. CITY OR TOWN CHANTILLY	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MINOR GILBERT KELLER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EVELYN ROMAINE McCLINTOCK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1951-1977		17. INFORMANT ADDRESS AMY JO KELLER, 14730 NATIONAL DRIVE, CHANTILLY, VA 22021	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY HEART DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>APRIL 1, 19 83</u> to <u>APRIL 4, 19 83</u> , that (I) (we) lost <u>above</u> the deceased alive on <u>APRIL 4, 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated					
22b. SIGNATURE MARION R. McMILLAN, LT, MC, USNR		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 5 Apr 83	
23a. BURIAL, CREMATION, REMOVAL SPECIES Cremation		23b. DATE 4-5-1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory	
24. FUNERAL DIRECTOR W.W. Chambers Inc, 8655 Georgia Ave. S S		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Prince Geo Md		25a. APPROVED BY: BY: REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 8 1983 Joan J. Laniel	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 48 hours after death.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Vivian R. Kelly</b>			20. DATE OF DEATH Month <b>April</b> Day <b>24</b> Year <b>1983</b>			2b. HOUR <b>1:35 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH <b>Feb. 10, 1938</b>		6. AGE (In years last birthday) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Montgomery</b> Md.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Prince Geo</b>		13c. INSIDE CITY LIMITS? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		13d. STREET AND NUMBER <b>7942 Lake Crest Drive</b>			
14. FATHER'S NAME First Middle Last <b>Tuscko nmnm Stilwell</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Sadie nmnm Janney</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>233-58-8874</b>			17. INFORMANT <b>Thomas H. Kelly</b>			Address <b>20770 See 13 E</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiovascular collapse</b> <b>5185</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>adult respiratory distress syndrome</b> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 days</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) UNDERLYING <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>April 16</b> , 1983, to <b>April 24</b> , 1983, that (I) <del>(we)</del> last saw the deceased alive on <b>April 24</b> , 1983, and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) (did not) view the body after death.									
22b. SIGNATURE <b>R. Eric Alving</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>26 April 83</b>			
22d. PHYSICIAN'S NAME (Type) <b>R. Eric Alving MD</b>				22e. ADDRESS <b>3327 Superior Lane, Bowie, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>4-28-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Silver Spring, Montg., Md.</b>			
24. FUNERAL DIRECTOR <b>W.W. Chambers Co</b>				ADDRESS <b>8655 Ga., Ave</b>		25a. REC'D BY REGISTRAR DATE <b>MAY 2 1983</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. Pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8310962			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>LEONARD ELTON KINGERY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 24 1983</b>		2b. HOUR P M <b>12:37 P M</b>	
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>JULY 22 1917</b>		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>65</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED U.S.N.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>	
13a. STATE <b>FLORIDA</b>		13b. COUNTY <b>ST. LUCIE</b>		13c. CITY OR TOWN <b>FT PIERCE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>GEORGE KINGERY</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>PEARL SHIVELY</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>1936-1967</b>		17. INFORMANT <b>MARJORIE S. KINGERY</b>		ADDRESS <b>zip 20814</b> <b>4818 MIDDLESEX LANE,</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>1629 IMMEDIATE CAUSE (a) PULMONARY EMBOLUS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>SQUAMOUS CELL LUNG CANCER</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>19</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 18, 19 83</b> , to <b>APRIL 24, 19 83</b> , that (I) (we) last saw the deceased alive on <b>APRIL 24, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (I) did not see the body after death, so state.)							
22b. SIGNATURE <i>[Signature]</i> DEGREE <b>MD</b>				22c. DATE SIGNED <b>25 April 83</b>		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>RONALD P. SEN, LT. MC, USNR</b>				22f. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 28 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Rockville, Montgomery, Md.</b>	
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>				24b. ADDRESS <b>Bethesda, Maryland</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 26 1983</b>	
				25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		8 3 1 0 9 6 3		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARTIN D. KISAMORE</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 28, 1983</b>		2b. HOUR <b>11:40 A.M.</b>			
3. SEX <b>Male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 27, 1910</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>72</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>West Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Sylvan Manor Nursing Home</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Maintenance</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Sanitation Co. unty</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md. 20833</b>				13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Brookeville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Scott - Kisamore</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sarah - Lantz</b>		13e. STREET ADDRESS <b>314 Market St. 20833</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		16b. SOCIAL SECURITY NO. <b>WWII 235-36-4560</b>		17. INFORMANT <b>Eva Plum</b>		Same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 arterioconstrictive heart disease gen.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. (a) <b>Hepatitis, chronic obstructive lung disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)					
21d. INJURY OCCURRED: WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN) COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/28 83</b> to <b>4/28 83</b> that (I) (we) (we) saw the deceased alive on <b>4/28 83</b> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Barry N. Rosenbaum, M.D.</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/28/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BARRY N. ROSENBAUM</b>				22e. ADDRESS <b>3720 FARRAGUT AVE. KEWESINGTON, MD. 20895</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>APR. 30, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Norbeck Mem. Park</b>		23d. LOCATION CITY OR TOWN <b>Olney</b>		COUNTY STATE <b>Mont. Md.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS H. BARBER</b>				ADDRESS <b>LAYTONSVILLE, MD. 20879</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 2 1983</b>			
						25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>			



MAY 8 1988  
J. S. Gail

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

cleared by Dr. John S. Rogers, MD

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		REG. NO.		8310964					
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward Flavelle KOSS				2a DATE OF DEATH MONTH DAY YEAR April 1, 1983		2b HOUR M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR June 18, 1983		6 AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7 UNDER 1 YEAR MONTHS DAYS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, DC		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD			
10 CITY OR TOWN OF DEATH Silver Spring		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8811 Colesville Rd. #903				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Pharmacist		12b KIND OF BUSINESS OR INDUSTRY Self-employed	
13a STATE Maryland		13b COUNTY Montgomery		13c CITY OR TOWN Sil. Spr.		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 20910 8811 Colesville Rd. #903	
14 FATHER'S NAME FIRST MIDDLE LAST Edward H. Koss				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b SOCIAL SECURITY NO. WW 11		17 INFORMANT ADDRESS 301 Sherwood Ave. Staunton, VA 24401 Michael K. Somers					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cadaver Arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>19 1980</u> to <u>April 1</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>April 1</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>V. John Murgolo, MD.</u>				DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED April 1, 1983	
22d PHYSICIAN'S NAME (TYPE OR PRINT) V. John Murgolo, MD.				22e ADDRESS 8811 Colesville Rd. Silver Spring Md 20910					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment		23b DATE 4-5-1983		23c NAME OF CEMETERY OR CREMATORY Ft. Lincoln Masoleum Brentwood Pr Geo. MD		23d LOCATION CITY OR TOWN COUNTY STATE			
24 FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.				ADDRESS P.O. Box 7428 Sil. Spr., MD 20902		25a DATE REC'D BY REGISTRAR APR 8 1983			

BP



W. H. H. H.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

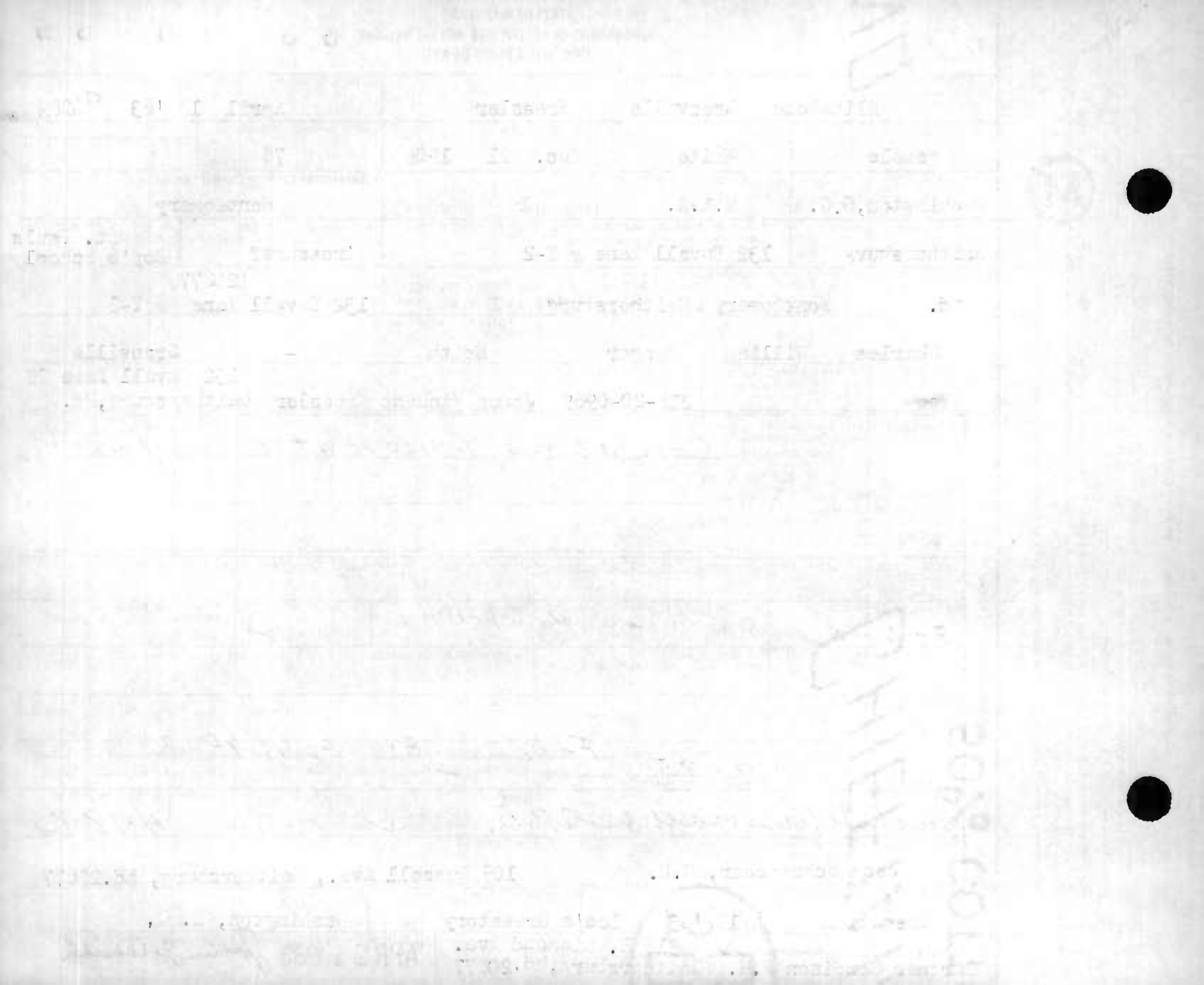
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 9 6 5			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
Elizabeth Granville Kressler				April 18 '83				9:00A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Dec. 21 1904		78 YRS.		MONTHS		DAYS	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Gaithersburg		132 Duvall Lane # T-2				Treasurer		St. Paul's Boy's School			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS (20877)			
Md. Montgomery Gaithersburg				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				132 Duvall Lane # T-2			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Charles William Hanger				Edith Granville							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				218-20-0969		James Vincent Kressler Gaithersburg, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Carcinoma, Pancreatic</u>										9 months	
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
9-6-82				Carcinoma, Pancreatic				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
				P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>Feb. 1981</u> , to <u>April 18, 1983</u> , that (I) <u>we</u> lost <u>saw</u> the deceased alive on <u>1-27-83</u> , 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>we</u> (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Jack Schumacher				M.D.						4-18-83	
23a. PHYSICIAN'S NAME (TYPE OR PRINT)				23b. ADDRESS							
Jack Schumacher, M.D.				105 Russell Ave., Gaithersburg, Md. 20877							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Cremation		4/19/83		Lee's Crematory		Washington, D. C.					
24. FUNERAL DIRECTOR				25. DATE REC'D. BY REGISTRAR				REGISTRAR'S SIGNATURE			
Gartner Sandison F.H. Gaithersburg, Md. 20877				APR 21 1983				John J. Cahill			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME OR TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10966	
1. DECEASED NAME (TYPE OR PRINT) <b>Sylvia Krout</b>						2a. DATE KNOWN OF DEATH <b>April 4, 1983</b>		7b. HOUR <b>8 AM</b>		7c. DAY <b>April 4, 1983</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Dec 11 1913</b>		6. AGE (IN YEARS) <b>69 YRS.</b>		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>April 14 1983</b>	
7d. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Massachusetts</b>				7e. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage Hill N.H.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>12805 Bluhill Rd</b>	
14. FATHER'S NAME <b>Jacob Freedman</b>				15. MOTHER'S MAIDEN NAME <b>Pauline Hoffman</b>				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>108-01-7881</b>				17. INFORMANT <b>Herman Krout; 12805 Bluhill Road</b>				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4920 IMMEDIATE CAUSE (a) <u>Cnephysoma &amp; Chr. obstruct. Pul.</u></b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>D.V.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>YES</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on. Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>[Signature]</b>				TITLE (SPECIFY) <b>M.D. Dep.</b>				MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4-15-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Judean Mem. Gardens</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Olney, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 21 1983</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



may be retained by the hospital or attending physician.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
1. FOR STATE REGISTRAR		Margaret S. Laffey				8 3 1 0 9 6 7 CERTIFICATE OF DEATH					
1. DECEASED NAME (TYPE OR PRINT)						2a. DATE OF DEATH			2b. HOUR		
Margaret S. Laffey						04/27/83			11:53 AM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Sept. 16, 1894		88		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Wisc.		U.S.A.				Montgomery MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									
Chevy Chase		Beth. Ret. And Nursing Center									
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Court Recorder				U.S. A.							
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Md. 20815				Montgomery		Chevy Chase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8700 Jones Mill Rd. 20813	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Henry F. Smith				Nellie				Searns			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No				399-07-3550D		Ernest Dematatis 806 - 15th St. N.W. D.C. Wash.,					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART 1. DEATH WAS CAUSED BY:											
4140 IMMEDIATE CAUSE: Intractable Heart Failure											
DUE TO, OR AS A CONSEQUENCE OF: (b) Arteriosclerotic Heart Disease											
DUE TO, OR AS A CONSEQUENCE OF: (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks											
2 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:											
Cerebral Vascular disease - Cerebral infarct - left hemiplegia											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED				21e. PLACE OF INJURY		21f. LOCATION					
WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 2/28, 19 83, to 4/27, 19 83, that (1) (a) last saw the deceased alive on 4/16, 19 83, and that in (my) (a) opinion death occurred on the date and hour and from the causes stated above (1) (a) (did not) view the body after death.											
22b. SIGNATURE				22c. DATE SIGNED				22d. ADDRESS			
J. Blaine Fitzgerald, M.D.				4/27/83				8218 Wisc. Ave. Beth., Md. 20814			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial				4/29/83		Holy Cross Cemetery		CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Joseph Gawler's Sons, Inc.				MAY 2, 1983				J. C. ...			
5130 Wisc. Ave. N.W. Wash., D.C. 20016											

BP \_\_\_\_\_



*[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page. Some words like "MAY 1944" and "RECEIVED" are faintly visible.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8310968	
1. FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Bernard A. Lancaster, Sr.				2a. DATE OF DEATH MONTH DAY YEAR April 28, 1983				2b. HOUR 10:45AM			
3. SEX Male		4. RACE Black		5. DATE OF BIRTH JUNE 17, 1920		6. AGE (IN YEARS LAST BIRTHDAY) 62		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Montgomery General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.			
13a. STATE Md.				13b. COUNTY Montg.		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST Isiah Lancaster				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Minnie Claggett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 218-09-0889		17. INFORMANT ADDRESS Merlee Lancaster (wife) same as #13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) <u>New Oat Cell Lung Carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 1/2 YRS.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>November</u> , 19 <u>80</u> , to <u>April 28</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>April 28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Eugene P. Flannery, MD				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/28/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EUGENE P. FLANNERY, MD				22e. ADDRESS 1811 PRINCE PHILIP DR. OLNEY, MD - 20832							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-3-83		23c. NAME OF CEMETERY OR CREMATORY Emory Grove Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Gaithersburg, Montg., MD			
24. FUNERAL DIRECTOR NAME George R. Snowden				24b. ADDRESS 246 N. Washington St. Rockville, Md. 20850		25a. DATE REG'D. BY REGISTRAR MAY 2 1983					



STANDARD FORM NO. 64



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 6 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR			
MINNIE						LASOVER		4-16-83								845 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		MONTHS		DAYS		HOURS			
Female		Cauc		1 26 96		87 5XXX YRS.													
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY			
NEW JERSEY		USA				Montgomery County MD.		HOUSEWIFE		AT HOME				MARYLAND		MONTGOMERY			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. STREET ADDRESS		13g. STREET ADDRESS		13h. STREET ADDRESS			
Bethesda		SUBURBAN HOSPITAL				WHEATON		YES XX NO <input type="checkbox"/>		3347 HEWITT AVE.		3347 HEWITT AVE.		3347 HEWITT AVE.		#20906			
4. FATHER'S NAME		5. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		17a. DATE OF DEATH		17b. DATE OF DEATH		17c. DATE OF DEATH		17d. DATE OF DEATH			
HYMAN		SARAH		NO		213-74-3078		MORRIS LASOVER		4-15-83		4-16-83		4-16-83		4-16-83			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)		19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20f. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20g. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		20h. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
Myocardial Infarction		1 day		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)		21d. LOCATION		21e. LOCATION		21f. LOCATION		21g. LOCATION		21h. LOCATION		21i. LOCATION			
22a. I certify that (1) (this hospital) attended the deceased from above, (2) (we) (did) not view the body after death.		22b. SIGNATURE		22c. DATE SIGNED		22d. ADDRESS		22e. ADDRESS		22f. ADDRESS		22g. ADDRESS		22h. ADDRESS		22i. ADDRESS			
		RAYMOND BASS		4-16-83		3929 Ferrara Wheaton, Md 20906		3929 Ferrara Wheaton, Md 20906		3929 Ferrara Wheaton, Md 20906		3929 Ferrara Wheaton, Md 20906		3929 Ferrara Wheaton, Md 20906		3929 Ferrara Wheaton, Md 20906			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		23e. LOCATION		23f. LOCATION		23g. LOCATION		23h. LOCATION		23i. LOCATION			
BURIAL		APR. 18, 1983		OHEL YAKOV		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE		BALTIMORE			
24. FUNERAL DIRECTOR		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE		24c. REGISTRAR'S SIGNATURE		24d. REGISTRAR'S SIGNATURE		24e. REGISTRAR'S SIGNATURE		24f. REGISTRAR'S SIGNATURE		24g. REGISTRAR'S SIGNATURE		24h. REGISTRAR'S SIGNATURE			
SOL LEVINSON & BROS., INC.		APR 20 1983		John J. Conish		John J. Conish		John J. Conish		John J. Conish		John J. Conish		John J. Conish		John J. Conish			
6010 REISTERSTOWN RD. BALTO., MD 21215																			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner will be notified in writing.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 9 7 0			
1- FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
hou Shee Lee				4 8 83 2:25A			
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (IN YEARS (LAST BIRTHDAY))	
Female		Oriental		May 8, 1904		78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
China		United States				Montgomery County MD	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda		Suburban Hospital		Laundry Worker		Laundry	
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
Maryland		Montgomery		Potomac		8800 Fox Hills Trail	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
UNKNOWN		UNKNOWN		No		184-34-5385	
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 Cardiac pulmonary arrest		19. DATE OF OPERATION		20a. AUTOPSY?	
Mrs. Mary Au, Daughter, Same as #13		DUE TO, OR AS A CONSEQUENCE OF (b) Acute respiratory failure		19a. CONDITION FOR WHICH OPERATION WAS PERFORMED		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of right lung				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:				YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		22c. DATE SIGNED	
		HOUR A.M. MONTH DAY YEAR				4/8/83	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/7 19 83, to 4/8 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. ADDRESS			
		Samuel D. Goldborg MD		11125 Rockville Pike Rockville, Md 20852			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		April 11, 1983		Oaklands Cemetery		West Chester, Pennsylvania	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Robert A. Pumphrey Funeral Homes, P.A., Bethesda, Maryland		APR 13 1983		[Signature]			

BP

Handwritten notes on lined paper, including a date "1911" and various illegible entries.

Vertical handwritten text on the right margin, possibly a date or page number.

Vertical handwritten text on the left margin, possibly a list or index.

Vertical handwritten text in the center-left margin, possibly a date or page number.

Handwritten text at the bottom center, possibly a signature or date.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3a should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 83 10971							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>BERNARD LEVIN</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>April 10, 1983</b>		2b. HOUR <b>9:08 a.m.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct 6, 1927</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash, DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11011 Oakwood Street</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Vice Pres(Ret)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Diaper Svc.</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Sil. Spg.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>11011 Oakwood Street</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Max Levin</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leah Shulman</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-28-6059</b>		17. INFORMANT ADDRESS <b>Ruth Levin; 11011 Oakwood St., SSpG, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>3352 IMMEDIATE CAUSE (a) RESPIRATORY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>AMYOTROPHIC LATERAL SCLEROSIS</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>9 years</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>NONE</b>									
19a. DATE OF OPERATION <b>NONE</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) <b>NONE</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 19 68</b> , to <b>APRIL 10, 19 83</b> , that (I) (we) lost saw the deceased alive on <b>APRIL 9, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Charles J. Bier, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4-10-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CHARLES J. BIER, M.D.</b>				22e. ADDRESS <b>1145-19th STREET, N.W., WASHINGTON, D.C. 20036</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-12-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Gdn.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Virginia</b>			
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>			

MEDICAL CERTIFICATION

4091 083

2018 7 17 PMT



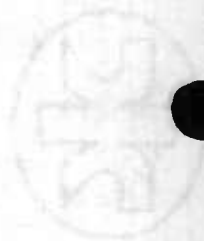
Item #526 Film G579 5/19/83 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 7 2

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Jeannette V Levy</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 / 15 / 83</b>			2b. HOUR <b>11 45 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 23 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>87</b>		7. YRS. <b>41</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fernwood Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-----</b>	
13a. STATE <b>Florida</b>		13b. COUNTY <b>Dade</b>		13c. CITY OR TOWN <b>Miami</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>784 Ridgewood Road</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph Victor</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Fannie Schlesinger</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>WW II</b>		17. INFORMANT <b>Harry Levy; 9708 Corkran Lane</b>				ADDRESS <b>Bethesda, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>3310 IMMEDIATE CAUSE (a) CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>ALZHEIMER'S DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASIXO</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>---</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>---</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY, OFFICE FARM, ETC.) <b>---</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>---</b>					
22a. I certify that (1) (this hospital) attended the deceased from <b>4/15/83</b> to <b>4/15/83</b> , that (1) (we) last saw the deceased alive on <b>4/15/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.									
22b. SIGNATURE <b>CARL MARGOLIS</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>4/16/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARL MARGOLIS</b>				22e. ADDRESS <b>11404 OLD GEORGETOWN RD., ROCKVILLE MD</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-19-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Magnolia Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Augusta, Georgia</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Dahzansky-Goldberg Chapels; 1170 Rockville Pike</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 19 1983</b>					
				25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 7 3

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Mitchel D. Lewis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 11, 1983</b>			2b. HOUR <b>11:13AM</b>			
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 6 1887</b>		6. AGE (IN YEARS (LAST BIRTHDAY)) <b>95</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Asst/ Ex. Sec.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Nat'l Mediation Bd.</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spr.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>3557 S. Leisure Blvd. 20906</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown Lewis</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown Duncan</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>---</b>		17. INFORMANT <b>Lela W. Lewis</b>		ADDRESS <b>3557 S. Leisure Blvd. Silver Spring, Md.</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

4408

IMMEDIATE CAUSE (a) **Cardiopulmonary arrest**

DUE TO, OR AS A CONSEQUENCE OF

(b) **Congestive Heart Failure**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Atherosclerotic vascular disease**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Intestinal obstruction**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) this hospital attended the deceased from <b>4-3</b> , 19 <b>83</b> , to <b>4-11</b> , 19 <b>83</b> , that (b) we lost saw the deceased alive on <b>4-10</b> , 19 <b>83</b> , and that in (c) our opinion death occurred on the date and hour and from the causes stated above. (If we) did not view the body after death.							
22b. SIGNATURE <b>A. ROTHMAN</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-11-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>A. ROTHMAN</b>		22e. ADDRESS <b>3701 Rossmore Blvd Silver Spring Md 20906</b>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/13/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D. C.</b>	
24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>		P.O. Box 7428 <b>Silver Spring, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Givier</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

45510



PROPERTY OF THE U.S. GOVERNMENT  
OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D.C. 20315

PROPERTY OF THE U.S. GOVERNMENT

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D.C. 20315

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WASHINGTON, D.C. 20315

PROPERTY OF THE U.S. GOVERNMENT  
OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D.C. 20315

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201  
clear with medical examiner 4/1/83  
TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. For a death occurring in a hospital, the certificate must be signed by the attending physician. For a death occurring elsewhere, the certificate must be signed by the attending physician or the medical examiner. If item 21 is marked on item 18, shows any injury, or other traumatic event, the medical examiner must be notified of the death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 3 1 0 9 7 4	
FOR Items 21a&21f 22a 1- STATE REGISTRATION film 578 4-28-83 cn										CERTIFICATE OF DEATH	
REG. NO.											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARIA C. Li Causi					2a. DATE OF DEATH MONTH DAY YEAR APRIL 1 83			2b. HOUR 11:30 A M			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec. 8, 1888		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Italy		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Olney		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brooke Grove Nursing Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS #6 Barn Ridge Court 20906			
14. FATHER'S NAME FIRST MIDDLE LAST Salvador Guarino			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rosaria (unknown)								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT Salvador F. Anselmo-nephew-(same as 13e)		ADDRESS				
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4130 Cardiorespiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronic liver disease DUE TO, OR AS A CONSEQUENCE OF (c) Acute mental syndrome APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4/1/83 3/4/83 1982											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: 10 none											
19a. DATE OF OPERATION 10/4/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cataract @ eye				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 P.M. 5 8 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) Fell on Quarry Home - Fr. Quilt.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOTWHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Nursing Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Brooks Grove Nursing Home Olney 20832							
22a. I certify that (I) (this hospital) attended the deceased from 4/1 19 83, to 4/1 19 83, that (I) (we) lost saw the deceased alive on 4/1 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE [Signature] ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 4/1/83							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. SCHOENBERG, MD				22e. ADDRESS 18111 Prince Philip Dr, Silver Spring							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-4-1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven Cemetery Silver Spring Montgomery Md.		23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home				1800 N.H. Ave., Silver Spring, Md.		25a. DATE REG'D. BY REGISTRAR APR 6 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			

Page 1395



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE MEDICAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elvin RICHARD Lidie			2a. DATE KNOWN OF DEATH XX MONTH DAY YEAR 3 11 19 83			2b. HOUR 9:50 a.m.			
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH MONTH DAY YEAR 3/17/27	6. AGE (IN YEARS) (LAST BIRTHDAY) 55 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD 3 11 19 83			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD			
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Cabinets	
13a. STATE Maryland		13b. CITY OR TOWN Montgomery Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20800 1222 High Wood Dr.			
14. FATHER'S NAME FIRST MIDDLE LAST Charles R. Lidie				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna May Anderson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		17. INFORMATION 21740 191 High St. 215-20-7638 Virginia Sellers/Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of Chest 9554 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 18.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:10xx 3 11 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) subject shot himself					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1940 Lewis Avenue, Rockville, Montgomery Co., Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>		TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER					DATE SIGNED 3-12-83		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 3/15/83		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Hagerstown, Wash. Md.		
24. FUNERAL HOME NAME ADDRESS Rest Haven Funeral Chapel, Inc. 601 Penna. Ave. Hagerstown, Md. 21740				25a. DATE REC'D BY REGISTRAR MAR 18 1983					REGISTRAR'S SIGNATURE <i>John J. Carver</i>



100-100

MEMORANDUM  
TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

[illegible text block]

[illegible text block]

[illegible text block]

CONFIDENTIAL

CONFIDENTIAL



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR Item 18ba Film 579 STATE REGISTRAR 5-5-83 cn				8 3 1 0 9 7 6 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Jacob E. Lieberman</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 9 83</b>				2b. HOUR <b>11 10 PM</b>	
1. SEX <b>M</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>2 12 13</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>70 YRS</b>		7. UNDER 1 YEAR MONTHS DAYS <b>70 YRS</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carriage 1411</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Biostatistician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US. GOVT</b>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD.</b>				13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>Kensington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Louis Lieberman</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>053-10-5771</b>		17. INFORMANT ADDRESS <b>Kensington, Md.</b> <b>Marie Lieberman; 10316 Parkwood Drive</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4860</b> <b>Acute Respiratory Failure</b> <b>Cardiorespiratory arrest</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>IMMEDIATE</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Syringomyelia with muscle wasting and</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Recurrent P (anion)</b> <b>marked diffuse motor weakness</b>								10 Yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <b>RECURRENT PNEUMONIA</b>									
19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>—</b>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET <b>—</b>		CITY OR TOWN <b>—</b>		COUNTY <b>—</b>	
22a. I certify that (this hospital) attended the deceased from <b>Dec. 8, 1982</b> to <b>April 9, 1983</b> , that (we) last saw the deceased alive on <b>April 9, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>James A. Rossi MD</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>4/10/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JAMES A. Rossi MD</b>				22e. ADDRESS <b>6111 EXECUTIVE BLVD., ROCKVILLE MD 20852</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-12-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>King David Mem. Garden</b>		23d. LOCATION CITY OR TOWN <b>Falls Church, Virginia</b>		COUNTY <b>—</b>	
24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>				ADDRESS <b>Rockville, Md.</b>		25a. DATE RECEIVED BY REGISTRAR <b>APR 14 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>	

U.S. DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

FROM THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

SUBJECT: [Illegible]

[Illegible text follows, appearing to be a memorandum or report.]

Very truly yours,  
[Illegible Signature]

Director, Bureau of Plant Industry

APR 19 1933

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

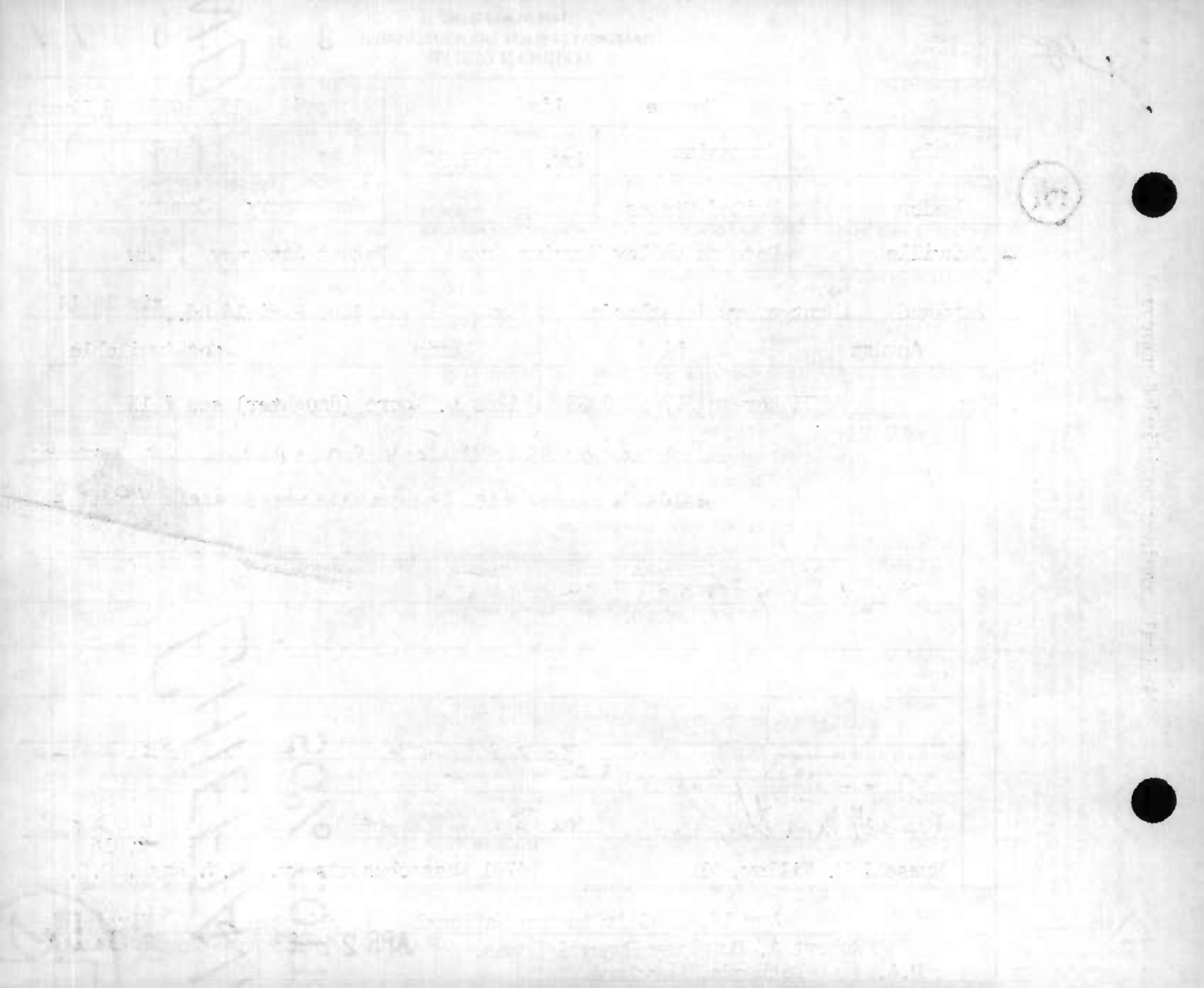
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 7 7

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <div style="display: flex; justify-content: space-around;"><span>John</span><span>Eugene</span><span>Lind</span></div>			2a. DATE OF DEATH MONTH DAY YEAR <div style="display: flex; justify-content: space-around;"><span>April</span><span>12,</span><span>1983</span></div>		2b. HOUR 12 Noon <sup>M</sup>	
3 SEX Male		4 RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR <div style="display: flex; justify-content: space-around;"><span>Nov.</span><span>5,</span><span>1892</span></div>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Sweden		7b. CITIZEN OF WHAT COUNTRY? United States		6. AGE (IN YEARS (LAST BIRTHDAY)) 89 YRS.		
10 CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Potomac Valley Nursing Home		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County <sup>MD</sup>		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Patent Attorney		12b. KIND OF BUSINESS OR INDUSTRY Law				
13a. STATE Maryland		13b. CITY OR TOWN Bethesda		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST <div style="display: flex; justify-content: space-around;"><span>August</span><span></span><span>Lind</span></div>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <div style="display: flex; justify-content: space-around;"><span>Maria</span><span></span><span>Not Available</span></div>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WWII Korean 577 01 9835		17. INFORMANT ADDRESS Miles L. Moore (daughter) see # 13		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardio-respiratory collapse</u> 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u> <u>years</u>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Biliary tract infection</u>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (the hospital) attended the deceased from <u>3-29</u> , 19 <u>83</u> , to <u>4-12</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>3-6</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.						
22b. SIGNATURE <u>Russell M. Tilley, M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 4-12-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Russell M. Tilley, MD		22e. ADDRESS 4701 Massachusetts Av., N.W. Wash. D.C. 20016				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Apr 15, 1983		23c. NAME OF CEMETERY OR CREMATORY Arlington National		
23d. LOCATION CITY OR TOWN COUNTY STATE Arlington Virginia						
24 FUNERAL DIRECTOR NAME Robert A. Pumphrey		24b. ADDRESS Funeral Homes, P.A., Bethesda, Maryland		25a. RECEIVED BY REGISTRAR APR 21 1983		
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					8310978 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Charles Gorman Linthicum					2a. DATE OF DEATH MONTH DAY YEAR 4 3 '83 2b. HOUR 6:05P <sub>M</sub>				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 30 1893		6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Boys		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 13100 W. Old Baltimore Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FARMER		12b. KIND OF BUSINESS OR INDUSTRY Farming	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md.		13b. COUNTY Montg		13c. CITY OR TOWN Boys		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20841 13100 W. Old Baltimore Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST George Linthicum				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HARSHA BEST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 522-10-9783		17. INFORMANT Son Charles T. Linthicum 14222 W. Old Balt. Road Boys, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema, acute</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Congestive heart failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Arteriosclerotic cardiovascular disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> <u>15 yrs.</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>7/1</u> , 19 <u>66</u> , to <u>4/3</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE <u>A. D. Bonifant</u>			DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED April 15, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>A. D. BONIFANT</u>			22e. ADDRESS <u>1811 Prince Philip Dr, Olney, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 6, 1983		23c. NAME OF CEMETERY OR CREMATORY Monocacy Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Beallsville, Maryland			
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY ADDRESS HOMES, P.A., ROCKVILLE, MARYLAND						25a. DATE REC'D. BY REGISTRAR APR 11 1983			
25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>									

BP

MEMORANDUM

TO : DIRECTOR, FBI (100-441111)

FROM : SAC, NEW YORK (100-100000)

SUBJECT: [Illegible]

RE: [Illegible]

[Illegible text follows]

RECEIVED  
FBI  
NEW YORK  
JUN 10 1964

U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10979

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		3. SEX		4. RACE		5. DATE OF BIRTH	
Bronnie Lee Loewy		FEMALE		WHITE		NOV. 10, 1932	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
NORTH CAROLINA		U.S.A.		51 YRS.		MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
SILVER SPRING		Holy Cross Hospital		FED. GOVT.			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
MD		MONTGOMERY		SILVER SPRING		YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
ROMIE E. LANGSTON		MARTHA JANE JOHNSON		No		239-44-1492	
17. INFORMANT		17. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
WILLIAM T. LOEWY		-825 NORTHWEST RD		Cerebral Vascular Accident			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION		CITY OR TOWN COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET			
22a. I certify that (I) (this hospital) attended the deceased from above, (I/we) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
4-15-83		G.B. Cushner		MD		4-15-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	
Gilbert Cushner		11161 New Hampshire Av. S.W.		Burial		Apr. 18, 1983	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR	
Dutchman Cemetery		Silver Spring, MD		TAKOMA FUNERAL HOME - WASHINGTON, D.C. 20012		APR 19 1983	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE		25d. REGISTRAR'S SIGNATURE		25e. REGISTRAR'S SIGNATURE	
John G. Carver		John G. Carver		John G. Carver		John G. Carver	



Handwritten notes and a table. The table has columns for 'Date', 'Time', and 'Remarks'. The 'Date' column contains '1/10/52' and '1/11/52'. The 'Time' column contains '10.00' and '10.15'. The 'Remarks' column contains '1st class' and '2nd class'. There is also a note '1st class' written vertically on the left side of the table.

Handwritten text: '1st class' written vertically.

20% COLLOID

Handwritten text at the bottom of the page, including '1st class' and '2nd class'.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR		83		10980		REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) Isabel O. Loftus				2a DATE OF DEATH 4 11 83		2b HOUR 9:30p M			
3 SEX Female		4 RACE White		5 DATE OF BIRTH 11 25 1903		6 AGE (IN YEARS LAST BIRTHDAY) 79 YRS		7a UNDER 1 YEAR MONTHS DAYS	
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7c CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10 CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood House N.H.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Librarian		12b KIND OF BUSINESS OR INDUSTRY Cath. School	
13a USUAL RESIDENCE (GIVE STREET ADDRESS) Md. 20034		13b COUNTY Montgomery		13c CITY OR TOWN Bethesda		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 20034 10407 Montrose Ave	
14 FATHER'S NAME Charles Orr				15. MOTHER'S MAIDEN NAME Mary Caldwell Unknown					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. None		17 INFORMANT Martin Loftus		17 ADDRESS 10407 Montrose Ave. Bethesda Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4860 Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pneumonia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from Nov. 14, 1980, to April 11, 1983, that (I) (we) last saw the deceased alive on above (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE Christopher Unger, M.D.				DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 4/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Christopher Unger, M.D.				22e ADDRESS 8218 Wisconsin Ave. Bethesda, Md. 20814					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 4/13/1983		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.			
24 FUNERAL DIRECTOR NAME Joseph Gawler's Sons		ADDRESS 5130 Wisc. Ave., Wash., D.C.		24b. DATE REC'D. BY REGISTRAR APR 18 1983		24c. REGISTRAR'S SIGNATURE John J. Conish			

100-58-1000

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>ANTONINO GIACOMO LONGO</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>APRIL 5 1983</b>			2b. DATE OF DEATH MONTH DAY YEAR <b>APRIL 5 1983</b>			2c. DATE OF DEATH MONTH DAY YEAR <b>APRIL 5 1983</b>			
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>SEPT 10, 1908</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>74</b> YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE OF DEATH MONTH DAY YEAR <b>APRIL 5 1983</b>			7d. DATE OF DEATH MONTH DAY YEAR <b>APRIL 5 1983</b>			
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ITALY</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b>			
10. CITY OR TOWN OF DEATH <b>SILVER SPRING</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>15300 PINE ORCHARD DRIVE</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>CHEF</b>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>MONTGOMERY</b>			13c. CITY OR TOWN <b>SILVER SPRING</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>PIETRO LONGO</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>UNKNOWN</b>			16. SOCIAL SECURITY NO. <b>577-03-5118</b>			17. INFORMANT <b>SON PETER LONGO</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>577-03-5118</b>			17. INFORMANT <b>SON PETER LONGO</b>			17. INFORMANT <b>MARCIA LANE ROCKVILLE, MD. 20851</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL DISEASE</b> 4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>NONE</b>												
19a. DATE OF OPERATION <b>NONE</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <i>John S. Rogers</i>			TITLE (SPECIFY) <b>M.D.</b>						DATE SIGNED <b>APRIL 6, 1983</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>JOHN S. ROGERS</b>			ADDRESS <b>1919 SEMINARY ROAD, SILVER SPRING, MD.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>4/9/83</b>			23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>SILVER SPRING MONT MD.</b>			
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b> ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 14 1983</b>			25b. REGISTRAR'S SIGNATURE <i>John J. Grieb</i>			



Wm. A. R. H. Co.  
New York, N.Y.

Wm. A. R. H. Co.  
New York, N.Y.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN COPIES OF THIS FORM FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10982	
1. DECEASED NAME (TYPE OR PRINT) <b>Ariadne Lowenthal</b>										2a. DATE KNOWN OF DEATH <b>April 26 1983</b>	
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH <b>Apr. 22, 1921</b>		6. AGE (LAST BIRTHDAY) <b>62 YRS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD <b>April 28 1983</b>		2d. HOUR <b>11:15 PM</b>	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Soviet Union</b>		11. CITIZEN OF WHAT COUNTRY? <b>United States</b>		12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>					
13a. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>13833 Dowleis Dr</b>				12b. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Corporation Officer</b>		12c. KIND OF BUSINESS <b>Machine Translation</b>			
13. STATE <b>MD</b> 13b. CITY <b>Mont</b> 13c. CITY OR TOWN <b>Rockville</b> 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <b>13833 Dowleis Dr</b>											
14. FATHER'S NAME <b>Wladimer B. Lukjanow</b>						15. MOTHER'S MAIDEN NAME <b>Maria Pavlonsky</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>348 26 6102A</b>		17. INFORMANT <b>Husband</b>		ADDRESS <b>Same as item 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>9350 Asphyxia</b> IMMEDIATE CAUSE (a) <b>Hanging</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Hanging</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Hanging</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>None</b>											
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH <b>96m 426 1983</b>				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4 26 1983</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>Hungry Self</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Dowleis Dr. Rockville Mont MD</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>John S. Rogers</b>				TITLE (SPECIFY) <b>Dep</b>				DATE SIGNED <b>April 27 1983</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers M.D.</b>				ADDRESS <b>1919 Seminary Rd., Silver Spring, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL <b>Cremation</b>				23b. DATE <b>April 28, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>			23d. LOCATION <b>Alexandria, Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY</b> ADDRESS <b>FUNERAL HOMES, P.A., ROCKVILLE, MARYLAND</b>						25a. DATE REC'D. BY REGISTRAR <b>MAY 2 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Canale</b>			

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(22)

EXHIBIT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 10983			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME [TYPE OR PRINT] <b>FEIGA LUBOZICKY</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4/3/83</b>		2b. HOUR <b>9:54 AM</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Jan. 5, 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Poland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Cuba</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOLIN SUCH FACILITY, GIVE STREET ADDRESS) <b>HOLY CROSS HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Potomac</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>David Lubozicky</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Sheina Reishes</b>		13e. STREET ADDRESS <b>9628 Trailridge Terrace (20854)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>218-66-5967</b>		17. INFORMANT ADDRESS <b>Maryland 20854</b> <b>Zoila Chernoff; 9628 Trailridge Terrace; Potomac</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gastrointestinal Hemorrhage</b> <b>2100</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic renal insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes mellitus</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24hr</b> <b>5 years</b> <b>5 years</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from <b>January 1982</b> to <b>April 3, 1983</b> , that (I) (we) lost saw the deceased alive on <b>April 3, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>[Signature]</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>April 3, 1983</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>BLAINE H. ETG</b>		22e. ADDRESS <b>9601 Georgia Ave Silver Spring Md 20902</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/6/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Park Cemetery Paramus; Burgen County; NJ</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>DANZANSKY-GOLDBERG MEM. CHAPLAIN</b>				25. REGISTRAR'S SIGNATURE DATE REC'D. BY REGISTRAR <b>APR 6 - 1983 [Signature]</b>			
1170 Rockville Pike; Rockville, Md. 20854							

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#10/83

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 1 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (1))  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10984	
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST John MIDDLE H. LAST Luckett		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.		7c. DATE PRONOUNCED DEAD	
male		black		Sept 08, 1905		75 YRS.		MONTHS DAYS HOURS MIN.		April 18, 1983	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				2d. HOUR	
Arkansas		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery				12:25 PM	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Silver Spring		Holy Cross Hospital		Cement Mason							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		20902	
Maryland		Montgomery		Silver Spring		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1135 Univ Blvd		Apt #408	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		No		435-10-4916		Walka Luckett (wife) same as #13			
Henry Luckett		Sophia ?									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4291 IMMEDIATE CAUSE (a)		Acute Myocardial Dis.		yrs.							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b) Chronic Myocardial Dis.									
		(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d).		None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?							
None				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION							
				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion			
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY		STATE	
Burial		4-22-83		Harmony Memorial Park		Landover, Pr. Geo., Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George R. Snowden		246 N. Washington St. Rockville, Md. 20850		APR 22 1983		John F. Canfield					

John Luckett  
Apr 18 53

Sept 2, 1907

Montgomery

211ver 207ing Holy Cross

Montgomery 211ver 207ing

1135 only line for 1907

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 83 10985	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Eunice V. Lunsford</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>April 25, 1983</b>			2b. HOUR <b>1:05 A.M.</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 9 01</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.					
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Memford Doggett</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>			13e. STREET ADDRESS <b>14639 Bauer Drive Apt. 208</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>577-26-4105</b>		17. INFORMANT <b>9907 Marguerita Ave. Patricia A. Rose Glenn Dale, Md. 20769</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b>											
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiac Shock</b>										12 hours	
DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Myocardial Infarction</b>										1 day	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Atherosclerotic Heart Disease</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>4/23 1983</b> to <b>4/25 1983</b> , that (I) (we) last saw the deceased alive on <b>4/24 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Leonard A. Wonski, MD</b>			22c. DATE SIGNED <b>4/25/83</b>			22d. ADDRESS <b>6410 Rockledge Dr., Bethesda, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>April 27, 83</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Manassas City Cem.</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Manassas Virginia</b>		
24. FUNERAL DIRECTOR NAME <b>Clifford C. Blum</b>			25a. DATE RECD. BY REGISTRAR <b>MAY 2 1983</b>			25b. REGISTRAR SIGNATURE <b>Joan G. Conish</b>					

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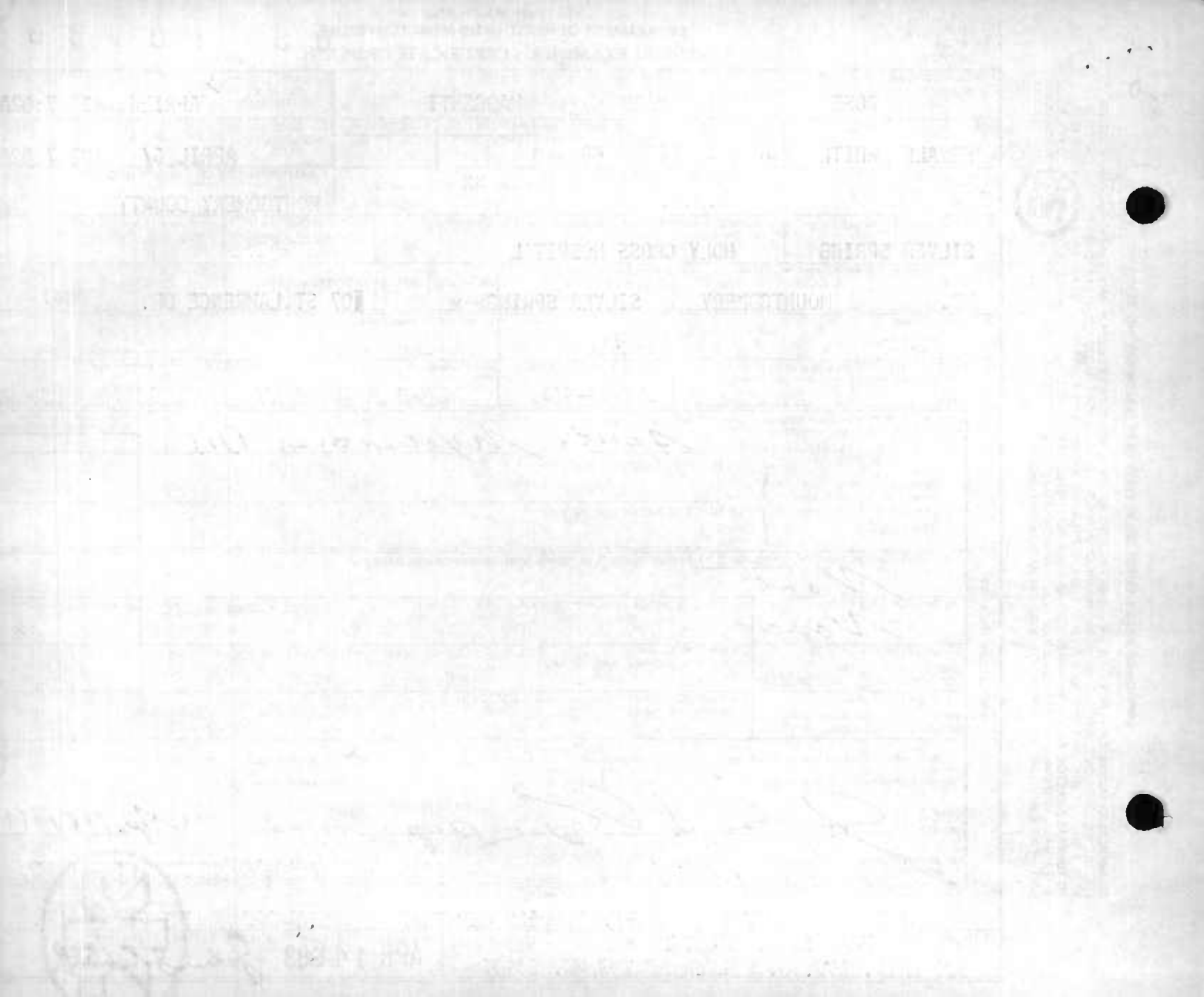
Handwritten text at the bottom of the page, possibly a date or signature.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10986									
1. FOR STATE REGISTRAR										7a. DATE KNOWN OF DEATH		MONTH DAY YEAR		7b. HOUR					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ROSE MARY MAGGENTI										APRIL 6, 1983		7:02A							
3. SEX		4. RACE		5. DATE OF BIRTH (MONTH DAY YEAR)		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEATH		7d. HOUR							
FEMALE		WHITE		JUNE 2, 1913		69 YRS.				APRIL 6/ 1983		7:02A							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH							
PENNSYLVANIA				U.S.A.								MONTGOMERY COUNTY MD.							
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
SILVER SPRING				HOLY CROSS HOSPITAL				HOUSEWIFE											
13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13a. STATE		13b. COUNTY		13c. CITY OR TOWN					
										MD.		MONTGOMERY		SILVER SPRING					
										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		20901					
14. FATHER'S NAME (FIRST MIDDLE LAST)										15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST)									
FRANK PINELLI										SUSAN BARBERIE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO.									
NO										578-26-9815									
17. INFORMANT										ADDRESS									
THOMAS J. MAGGENTI										SAME AS 13 HUSBAND									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u> DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4291																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										(b) DUE TO, OR AS A CONSEQUENCE OF									
										(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
None																			
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									
None																			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR									
										P.M. 19									
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)									
										21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE										TITLE (SPECIFY)									
JOHN S. ROGERS										M.D. Dep									
EXAMINER'S NAME (TYPE OR PRINT)										ADDRESS									
JOHN S. ROGERS										1919 SEMINARY ROAD, SILVER SPRING, MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)										23b. DATE									
BURIAL										4/9/83									
23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE									
FT. LINCOLN CEMETERY										BRENTWOOD PRI GEO MD.									
24. FUNERAL DIRECTOR NAME										25a. DATE REC'D. BY REGISTRAR									
FRANCIS J. COLLINS										APR 14 1983									
25b. REGISTRAR'S SIGNATURE																			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901										John J. Connel									

BP



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 10987

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NINA E. Magrum			2a. DATE OF DEATH MONTH DAY YEAR 4-24 83			2b. HOUR 5 p.m.			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 4 28 84		6. AGE (IN YEARS LAST BIRTHDAY) 98		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) US		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Mont Co			
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN Takoma Park		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7304 Birch Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Harper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Young					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <input checked="" type="checkbox"/> No				16b. SOCIAL SECURITY NO. 578 66 8188		17. INFORMANT ADDRESS Elizabeth Fisher, 7304 Birch Ave., TP, Md. 20912			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Sepsis

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
2 wks

4413  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) Perforated necrotic Bowel

12 days

DUE TO, OR AS A CONSEQUENCE OF

(c) Ruptured Abdominal Aortic Aneurysm

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

Renal failure

19a. DATE OF OPERATION

4-11-83

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

Ruptured Abd Aortic Aneurysm

20a. AUTOPSY?

YES ☐ NO ☐20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)

21d. INJURY OCCURRED  
WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 4-11-83, to 4-24-83, that (I) (we) last saw the deceased alive on 4-24-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING  
PHYSICIAN ☒MEDICAL  
DIRECTOR ☐STAFF  
PHYSICIAN ☐

22c. DATE SIGNED

4-25-83

22e. PHYSICIAN'S NAME (TYPE OR PRINT)

John W E Douglas Jones

22e. ADDRESS

10315 Georgia Ave Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY)

Burial.

23b. DATE

April 27, 1983

23c. NAME OF CEMETERY OR CREMATORY

National Mem. Pk, Falls Ch, Va.

23d. LOCATION

CITY OR TOWN

COUNTY

STATE

24. FUNERAL DIRECTOR

Takoma Funeral Home Inc  
Robert Walters

25a. DATE REC'D. BY REGISTRAR

254 Carroll St. N. W.

25b. DATE REC'D. BY REGISTRAR

DAPR-27 1983

25c. REGISTRAR'S SIGNATURE

John J. Anish

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

11

11

Handwritten notes and tables, mostly illegible due to fading. The text appears to be organized into rows and columns, possibly representing a ledger or a series of data points. Some legible fragments include:

- Top center: "11" and "11" (possibly dates or identifiers).
- Bottom center: "11" and "11" (possibly dates or identifiers).
- Bottom right: "11" and "11" (possibly dates or identifiers).

BH

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 7 8 8  
REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>JAMES EMANUEL MAIDANOS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 5, 1983</b>		2b. HOUR <b>8:00<sup>P</sup></b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>JUNE 26, 1921</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Turkey</b>	7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>THE CLINICAL CENTER, NIH</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Bartender</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>
13a. STATE <b>DELAWARE</b>		13b. COUNTY <b>New Castle</b>	13c. CITY OR TOWN <b>WILMINGTON</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Emanuel D. Maidanos</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Panagiota Not available</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>132-09-3199</b>		17. INFORMANT ADDRESS <b>MRS. EMILY MAIDANOS (WIFE) same as above</b>	

18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c):  
PART 1. DEATH WAS CAUSED BY:

2028	IMMEDIATE CAUSE (a)	<b>Acute (Subacute) Renal Failure, Hypotension</b>	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)	<b>Diffuse Mixed Lymphoma</b>	<b>9 months</b>
	(c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **no**

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>MARCH 18, 1983</b> , to <b>APRIL 5, 1983</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>APRIL 5, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (did not) view the body after death.			
22b. SIGNATURE <i>Antonio Folo</i>	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>4/6/83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ANTONIO FOLO</b>		22e. ADDRESS <b>NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MARYLAND 20205</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>April 9, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Silverbrook Cemetery</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Wilmington Delaware</b>
24. FUNERAL DIRECTOR NAME <b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A. BETHESDA, MARYLAND</b>		25. DATE REC'D. BY REGISTRAR <b>APR 15 1983</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF WASHINGTON

PAFFININ

20% COLDOMIT



MD

X

4/1/13

MISS J. J. J.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, REQUIRING 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP  
DHMH - 17  
(VR A15 ME (1))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Leonard</b>			FIRST			MIDDLE			LAST <b>Makowski</b>			2a. DATE KNOWN OF DEATH ESTIMATED <b>4/20</b> 19 <b>83</b>			2b. HOUR <b>12:21</b> P. M.				
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Dec. 19, 1929</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>53</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>4/20</b> 19 <b>83</b>			2d. HOUR <b>12:21</b> P. M.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.							
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>2406 Lindell Street</b>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Division Supervisor</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>METRO</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2406 Lindell Street 20902</b>											
14. FATHER'S NAME FIRST MIDDLE LAST <b>Joseph Makowski</b>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Theodora Zeleski</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		(IF YES, GIVE WAR OR DATES) <b>Korean</b>		16b. SOCIAL SECURITY NO. <b>178-20-0204</b>		17. INFORMANT ADDRESS <b>Doris R. Makowski Same as 13 Wife</b>													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4291</b> IMMEDIATE CAUSE (a) <b>Acute myocardial disease.</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <b>None</b>																			
19a. DATE OF OPERATION <b>None</b>						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>None</b>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b>				TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER <b>1919 Seminary Road</b>						DATE SIGNED <b>4/20/83</b>									
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>				ADDRESS <b>Silver Spring, Montgomery, Md.</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4/23/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont Md.</b>									
24. FUNERAL DIRECTOR NAME <b>Francis J. Collins</b>										25a. DATE REC'D. BY REGISTRAR <b>APR 28 1983</b>				25b. REGISTRAR'S SIGNATURE <b>John J. Canfield</b>					
500 Univ. Blvd., W., Silver Spring, Md. 20901																			





Male White no. 29, 1923 27

river spring 2000 Mammals 2000

Montgomery river spring 2000 Mammals 2000

South experimental disease.

None

None

None

John G. Brown, M.D.

John G. Brown, M.D.



Montgomery Co.

RECEIVED

NOV 11 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, page 3 by the funeral home, and page 4 within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the Medical Examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83

10991

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR P M	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST		Kenneth Wayne Margretta		April 23, 1983 12:15 P M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS (LAST BIRTHDAY))	7. IF UNDER 1 YEAR MONTHS DAYS	
Male	White	March 10, 1968	15 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Pennsylvania	USA		Montgomery County MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Clinical Center, Bethesda, Md.		student		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS	
Pennsylvania		E. Stroudsburg		69 Prospect Street 18301	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Kenneth W. Magretta, Sr.		Cheryl Arnold			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no		none		same as patient	
Mr. Kenneth W. Margretta, Sr. (father)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) <u>BURKITT'S LYMPHOMA INVOLVING PERIRENAL</u>					
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) <u>AND PERIURETERAL TISSUES WITH HYDRONEPHROSIS</u>					
DUE TO, OR AS A CONSEQUENCE OF					
(c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		P.M. 19			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>June 22</u> , 19 <u>82</u> , to <u>April 23</u> , 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>April 23</u> , 19 <u>83</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Ann E. Alaoglu</u>		M.D.		April 24, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
ANN E. ALAOGLU		National Institutes of Health Clinical Center, Bethesda, Md. 20205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		4-27-83		Laurelwood Cemetery, Stroudsburg, Pa.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Marshall's Funeral Home		APR 27 1983		<u>John J. Conish</u>	
4217 9th St NW: Washington, D.C.					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with your office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 9 2

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>WILLIAM JEFFERSON MARSHALL</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 27 1983</b>		2b. HOUR <b>7:17 P<sub>M</sub></b>
3. SEX <b>MALE</b>	4. RACE <b>CAUCASIAN</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>FEBRUARY 15 1903</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>KENTUCKY</b>	7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.	
10. CITY OR TOWN OF DEATH <b>BETHESDA</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>NAVAL HOSPITAL</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>RETIRED</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. NAVY</b>	
13a. STATE <b>VIRGINIA</b>		13b. COUNTY <b>FAIRFAX</b>	13c. CITY OR TOWN <b>VIENNA</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>9738 LAWYERS ROAD</b> 99999
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM JEFFERSON MARSHALL</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LELIA YEAMAN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>1921-1959</b>	17. INFORMANT ADDRESS <b>CATHARINE W. MARSHALL, 9738 LAWYERS ROAD,</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

7999 IMMEDIATE CAUSE (a) **MULTIPLE SYSTEM FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

(b) \_\_\_\_\_  
DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 27, 19 83</b> , to <b>APRIL 27, 19 83</b> , that (I) (we) last saw the deceased alive on <b>APRIL 27, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <i>Dennis L. Azuma</i> LT MC	DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>29 Apr 83</b>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DENNIS L. AZUMA, LT, MC, USNR</b>		22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>May 2, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Money &amp; King Vienna Funeral Home, Inc. Vienna, Va.</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 10 1983</b>	
		REGISTRAR'S SIGNATURE <i>John J. Canine</i>	



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EX-100



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
Lee		E. S. Martz		April 9, 1983		8:47A		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Male		White		MONTH DAY YEAR		80 YRS		MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U.S.A.		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery County		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Olney		Montgomery General Hospital		Plumber					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET ADDRESS		13e. INSIDE CITY LIMITS?	
Maryland		Montgomery		Damascus		26824 Overlook St.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Elias		Cora		No		217-10-2896		James Lee Martz	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Obstructive Pulmonary Disease</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		5 years					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <u>Chronic Urinary Retention &amp; Prostatic Hypertrophy</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from April 8, 1983, to April 9, 1983, that (I) (we) last saw the deceased on April 8, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Lewis Kellert, M.D.		M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		4/9/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DATE REC'D. BY REGISTRAR		22g. REGISTRAR'S SIGNATURE			
Lewis Kellert, M.D.		1811 Prince Phillip Dr. Olney, Md. 20832		APR 12 1983		John J. Canine			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Apr. 12, 1983		Boonesboro		Boonesboro, Wash., Md.			
24. FUNERAL DIRECTOR		24a. DATE REC'D. BY REGISTRAR		24b. REGISTRAR'S SIGNATURE					
Orin L. Molesworth, P.A., Damascus, Md.		APR 12 1983		John J. Canine					

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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(VR A15 ME (5))  
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 10994	
1. DECEASED NAME (TYPE OR PRINT) <b>Gertrude L. May</b>										2a. DATE KNOWN OF DEATH <b>April 28 1983</b>		2b. HOUR <b>2:00</b>	
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>April 21 1928</b>		6. AGE (IN YEARS) <b>55</b>		7. IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>		7c. DATE PRONOUNCED DEAD <b>April 28 1983</b>		7d. HOUR <b>2:00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>				7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>			
10. CITY OR TOWN OF DEATH <b>Olney</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Mont. Gen. Hosp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>MD</b>				13b. COUNTY <b>Montgomery</b>				13c. CITY OR TOWN <b>Rockville</b>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME (FIRST MIDDLE LAST) <b>William Clark Smith</b>				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) <b>Gertrude Miller</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>210-20-3889</b>	
17. INFORMANT (Daughter) <b>Delores Fleischmann</b>				17. ADDRESS <b>5209 Norbeck Rd. Rockville</b>				17c. Zip Code: <b>20853</b>				17d. STREET ADDRESS <b>5209 Norbeck Rd</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>4291</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF: Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Chronic Myocardial Dis. Kr.</b> DUE TO, OR AS A CONSEQUENCE OF: (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION <b>None</b>													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
22b. TITLE (SPECIFY) <b>Dep.</b> MEDICAL EXAMINER													
22c. DATE <b>April 28 1983</b>													
22d. EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>													
22e. ADDRESS <b>1919 Seminary Rd. Silver Spring, Md.</b>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>May 2, 1983</b>				23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hill Memorial</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Seneca, Venango Co., Penna</b>	
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Homes, P.A., Rockville, Maryland</b>													
25a. DATE REC'D. BY REGISTRAR <b>MAY 10 1983</b>													
25b. REGISTRAR'S SIGNATURE <b>John J. Carver</b>													

REBIL 10110

DND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR					STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 1 0 9 9 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) John S. Mayfield					2a. DATE OF DEATH MONTH DAY YEAR 4/26/83			2b. HOUR 7:45 P.M.
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12-3-04		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Curator		12b. KIND OF BUSINESS OR INDUSTRY University		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda	
14. FATHER'S NAME FIRST MIDDLE LAST Earle B. Mayfield					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ora Lumpkin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT ADDRESS Edith S. Mayfield, same as #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Obstructive Pulmonary Disease DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic Renal Cell Carcinoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
19a. DATE OF OPERATION 4/20/83			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Renal Cell Carcinoma			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/11/83, to 4/26/83, that (I) (we) last saw the deceased alive on 4/26/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE John A. Nardi			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/27/83
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John A. Nardi MD			22e. ADDRESS 8215 Woodman Ave Bethesda Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE April 28, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814					25a. DATE REC'D. BY REGISTRAR MAY 2 1983		25b. REGISTRAR'S SIGNATURE John J. Connel	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 9 9 6			
FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Barbara Maria Mc ADAMS				2a. DATE OF DEATH MONTH DAY YEAR APR 29 83		2b. HOUR 4:20 P.M.	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 2, 1896		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.	
10. CITY OR TOWN OF DEATH Kensington		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 5606 Forest Place		13f. ZIP CODE 20814					
14. FATHER'S NAME FIRST MIDDLE LAST Manuel R. Martinez				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Sandin			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 065-24-2585		17. INFORMANT ADDRESS John McAdams Son same as 13e			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>BRONCHO PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONTRIBUTING TO DEATH</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED: (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from <u>APR. 26</u> 19 <u>85</u> to <u>APR 29</u> 19 <u>85</u> that (1) <u>we</u> saw the deceased alive on <u>APR 29</u> 19 <u>85</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If we did not visit the body after death, so state.)							
22b. SIGNATURE <u>Robert T. Thibadeau</u> DEGREE <u>MD</u>				22c. DATE SIGNED <u>4-29-83</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT T. THIBADEAU</u>				22e. ADDRESS <u>ROCKVILLE MD</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE May 4, 1983		23c. NAME OF CEMETERY OR CREMATORY P.R. National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bayamon Puerto Rico	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey				25a. DATE REC'D. BY REGISTRAR <u>MAY 2 1983</u>			
ADDRESS P.A., Bethesda, Maryland				25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u>			

BP





CHIEF OF BUREAU



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 0 9 9 7	
1. FOR STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Louise M. McAttee</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>4-11-83</i>		2b. HOUR <i>8<sup>44</sup> A M</i>
3. SEX <i>Female</i>	4. RACE <i>White</i>	5. DATE OF BIRTH MONTH DAY YEAR <i>8-27-10</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>72</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Wash. D.C.</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Montgomery County</i> MD	
10. CITY OR TOWN OF DEATH <i>Silver Spring</i>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Holy Cross Hospital</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>own home</i>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN <i>Maryland Prince Georges Hyattsville</i>		13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS <i>2406 Cherokee St., 20783</i>		
14. FATHER'S NAME FIRST MIDDLE LAST <i>Walter P. Fowler</i>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Mary E. Jeffries</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>N/A</i>	(IF YES, GIVE WAR OR DATES) <i>N/A</i>	16b. SOCIAL SECURITY NO. <i>217 52 5775</i>	17. INFORMANT ADDRESS <i>Frank McAttee, Jr.-husband-(same as 13c)</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> <i>4360</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebral Artery work</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 1/2 days</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <i>Arteriosclerosis Hypertension and Cerebrovascular Disease</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>May</i> 19 <i>82</i> to <i>April 11, 1983</i> , that (I) <del>lost</del> saw the deceased alive on <i>April 10, 1983</i> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>have</del> <i>did not</i> view the body after death.					
22b. SIGNATURE <i>Morton Altschuler, M.D.</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>4/11/83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Morton Altschuler, M.D.</i>		22e. ADDRESS <i>1299 - LAMBERTON TR. Silver Spring and</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>4-14-1983</i>	23c. NAME OF CEMETERY OR CREMATORY <i>George Washington</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Adelphi Pr. Georges Md.</i>
24. FUNERAL DIRECTOR NAME <i>Hines/Rinaldi Funeral Home</i>		11800 N.H. Ave., <i>Silver Spring, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>APR 14 1983</i>	
				25b. REGISTRAR'S SIGNATURE <i>John J. Smith</i>	

BP

RECEIVED  
JAN 10 1964



RECEIVED  
JAN 10 1964

RECEIVED  
JAN 10 1964



RECEIVED  
JAN 10 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 0 9 9 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>HELEN</b>		FIRST <b>Helen</b>	MIDDLE <b>W</b>	LAST <b>McAuliffe</b>	2a. DATE OF DEATH MONTH DAY YEAR <b>4-12-83</b>		2b. HOUR <b>1 A</b> M	
3. SEX <b>FEMALE</b>		4. RACE <b>W. hite</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4-19-97</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Wash. D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD		
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARRIAGE HILL 9101 2ND AVE S. Sp</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>KINDERGARTEN TEACHER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Education</b>
13a. STATE <b>MD 20815</b>		13b. COUNTY <b>MONTGOMERY</b>		13c. CITY OR TOWN <b>Chevy Chase</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>WILLIAM R WHITMAN</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MINERIA SQUIRE</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>				
16b. SOCIAL SECURITY NO. <b>577-84-1286</b>		17. INFORMANT <b>PATRICIA McAULIFFE</b>		ADDRESS <b>4515 WILLARD AVE CHASE MD</b>				

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**4379**

DUE TO, OR AS A CONSEQUENCE OF -

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **Cerebral insufficiency**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Arteriosclerosis**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**Seizure disorder**

19a. DATE OF OPERATION <b>none</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— — — 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) <b>—</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>—</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>— — — — —</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 30, 1982</b> , to <b>present</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>April 9, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John S. Umbell MD</b>		DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/12/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John S. Umbell MD</b>		22e. ADDRESS <b>8805 Conn. Ave., Chevy Chase, Md.</b>					

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/15/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b> <b>5130 Wisc. Ave., N.W. Wash., D.C.</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 21 1983</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 3 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THERE ARE ANY CHANGES TO BE MADE, WRITE THEM IN PENCIL IN THE MARGINS OF THIS PAGE. IF THERE ARE ANY CHANGES TO BE MADE, WRITE THEM IN PENCIL IN THE MARGINS OF THIS PAGE. IF THERE ARE ANY CHANGES TO BE MADE, WRITE THEM IN PENCIL IN THE MARGINS OF THIS PAGE.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 10999	
1. DECEASED NAME (TYPE OR PRINT) <b>William McCloud</b>										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 4 19 83, 10:18	
3. SEX <b>male</b>	4. RACE <b>black</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>1 17 25</b>	6. AGE (IN YEARS) (LAST BIRTHDAY) <b>58</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD <b>4 19 83</b>	2d. HOUR <b>10:18a</b>				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>S. C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Takoma Park</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist HOsptial</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Govt.</b>			
13a. STATE <b>D.C.</b>		13b. COUNTY <b>NA</b>		13c. CITY OR TOWN <b>Washington</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>245 Oglethorpe St N.E.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Talmadge McCloud</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Arsonia Workman</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>578 22 8584</b>		17. INFORMANT <b>Mrs. Lucille McCloud/wife/same as 13e</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: <b>4291</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Chronic Myocardial Dis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>											
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>[Signature]</b>		TITLE (SPECIFY) <b>M.D. Dep.</b>						MEDICAL EXAMINER		DATE SIGNED <b>April 19 1983</b>	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-22-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Memorial</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Md.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>John T. Rhines Co., 3015 12th St. N.E., D.C. 20017</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 28 1983</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

SECRET

SECRET





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH-17  
(VR A15 ME (5))  
15M2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR  
1- STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Richard A. McConniel			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 4/4/1983			2b. HOUR 6:16p	
3. SEX male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10/6/32	6. AGE IN YEARS (LAST BIRTHDAY) 50 YRS	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 4/4/83 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Dakota		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD	
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Officer		12b. KIND OF BUSINESS OR INDUSTRY Army Salvation
13a. STATE MD		13b. CITY OR TOWN MONTGOMERY/CHEVY CHASE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS W. THORNAPPLE ST 20815 #4211	
14. FATHER'S NAME FIRST MIDDLE LAST Herman Monroe McConniel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Prouty				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1952/1956 506-28-4249		17. INFORMANT ADDRESS N. Richland Hills, Texas David H McConniel. 6108-A Glenview Drive			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) CORONARY THROMBOSIS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE 4/VS							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? —				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 3:25 P.M. 4 4 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) COLLAPSED AT HOME			
21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) HOME		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4211 W. THORNAPPLE CHEVY CHASE MONTGOMERY MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE Francis C. Mayle		TITLE (SPECIFY) M.D. Dist		MEDICAL EXAMINER		DATE SIGNED 4/4/83	
EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle		ADDRESS 8100 Wisconsin Blvd Bethesda MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial/ Removal		23b. DATE 4/6/1983		23c. NAME OF CEMETERY OR CREMATORY West View Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Atlanta Georgia	
24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR APR 11 1983			
				REGISTRAR'S SIGNATURE John J. Canard			



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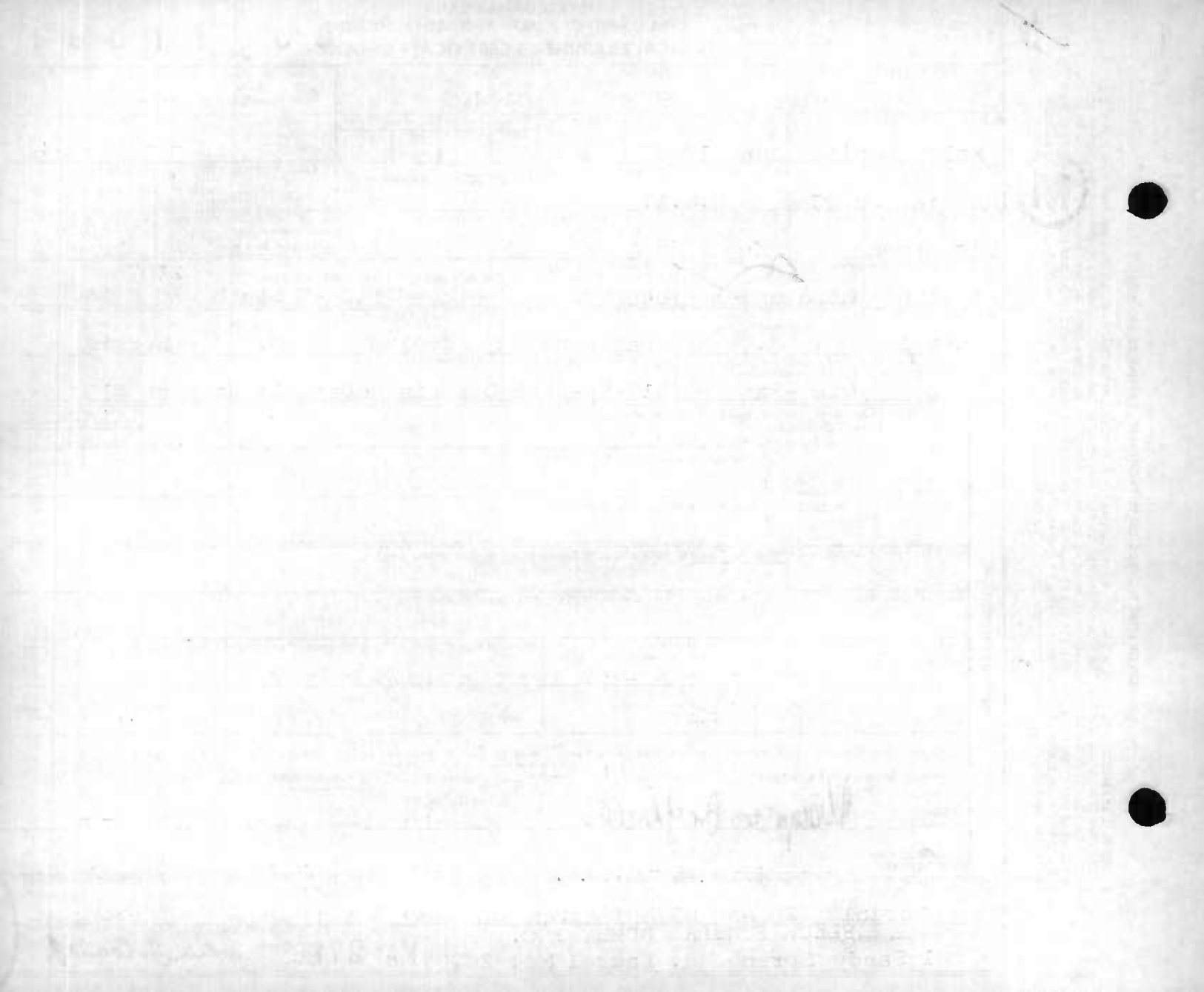
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11001	
1. DECEASED NAME (TYPE OR PRINT) <b>THOMAS EUGENE MCDANIELS</b>						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH <sup>01</sup> DAY YEAR <b>2-?-83</b>		2b. HOUR <b>2:54P</b>			
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>June 12 57</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>25 YRS.</b>	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR <b>5-7-83</b>		2d. HOUR <b>2:54P</b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington DC</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b>					
10. CITY OR TOWN OF DEATH <b>Dickerson</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Potomac River Bank</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Technician</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Army</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>AnnArundel</b>		13c. CITY OR TOWN <b>Hanover</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>21076 126-B South Ridge Rd.</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charley J. McDaniels</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Evelyn M. Morris</b>			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes Viet-Nam</b>					
16a. SOCIAL SECURITY NO. <b>215-66-8883</b>			17. INFORMANT ADDRESS <b>Cynthia McDaniels Same as #13e</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>9840 IMMEDIATE CAUSE (a) Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>? P.M. 2-?-83 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>subject found in water</b>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>river</b>		21i. LOCATION STREET CITY OR TOWN COUNTY STATE <b>Potomac River Montgomery Co., Maryland</b>						
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margaret A. Korell</i>			TITLE (SPECIFY) <b>M.D. Assistant</b>				DATE SIGNED <b>5-8-83</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>			ADDRESS <b>111 Penn Street</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>26 May 83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Arlington Virginia</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>FLECK FUNERAL HOME, INC. 7601 Sandy Spring Rd. Laurel Md. 20707</b>					25a. DATE REC'D. BY REGISTRAR <b>MAY 27 1983</b>		25b. REGISTRAR'S SIGNATURE <i>John J. Canich</i>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 11002

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BERTHA V. MacGUINN		2a. DATE OF DEATH MONTH DAY YEAR 4-15-83		2b. HOUR 10:40 A.M.	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR FEB 10 1889		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 94 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.	
10. CITY OR TOWN OF DEATH TAYLOR PARK		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WASHINGTON ADVENTIST HOSP.		12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) C & P. PHONE C		12b. KIND OF BUSINESS OR INDUSTRY (RETIRED)	
13a. STATE MD		13b. COUNTY PR GE.		13c. CITY OR TOWN HYATTSVILLE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM PEARSON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELIZABETH COSTELLO		13e. STREET ADDRESS 2027 ROANOKE ST		13f. STREET ADDRESS 20912	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 577-32-3898		17. INFORMANT JESSIE H. MacGUINN		ADDRESS 2027 ROANOKE ST	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) CORONARY HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)		21d. LOCATION CITY OR TOWN COUNTY STATE	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		21g. LOCATION CITY OR TOWN		21h. LOCATION COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 4-9-83, to 4-15-83, that (I) (we) last saw the deceased alive on 4-14-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE Boris RABKIN		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-15-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BORIS RABKIN		22e. ADDRESS 1019 Union Blvd, East Silver Spring		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE APR 19. 1983	
23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CEMETERY		23d. LOCATION CITY OR TOWN SUITLAND		23e. COUNTY MD		23f. STATE MD	
24. FUNERAL DIRECTOR NAME TAKOMA FUNERAL HOME		24a. ADDRESS 1510 CAMDEN AVE NW DE		25a. DATE REC'D. BY REGISTRAR APR 19 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

BP

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11-2-60 11-2-60

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH YOUR FILES, AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Ethlyn Bearden McGuire			2a. DATE KNOWN OF DEATH 4/24/83			2b. HOUR 7:15 A		
3. SEX Female	4. RACE White	5. DATE OF BIRTH Sept. 29 1907	6. AGE (IN YEARS) 75	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 4/24/83	7d. HOUR A		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alabama		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD		
10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION 3324 Jones Bridge Court			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U S Gov't. Retired		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. CITY OR TOWN Mont.		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3324 Jones Bridge Court		
14. FATHER'S NAME FIRST MIDDLE LAST Walter H. Bearden			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Yates			16. SOCIAL SECURITY NO. 264 12 3942		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) None		16b. SOCIAL SECURITY NO. 264 12 3942		17. INFORMANT Jerrine White (Sister)		17. ADDRESS 1220 Blair Mill Road S.S.Md. 20910		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 8909 IMMEDIATE CAUSE (a) Smoke and Soot Inhalation DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:56 PM 4/24/83		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject in housefire				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 3324 Jones Bridge Court, Chevy Chase, Montg., Md.				
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE Dennis F. Smyth, M.D.		TITLE (SPECIFY) Assistant MEDICAL EXAMINER			DATE SIGNED 4/25/83			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL SPECIFY Burial		23b. DATE 4/28/83		23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rockville Mont. Maryland		
24. FUNERAL DIRECTOR NAME Hines/Rinaldi				11800 N.H.Ave.S.S.Md.		25a. DATE REC'D. BY REGISTRAR APR 26 1983		25b. REGISTRAR'S SIGNATURE John J. Connel





ONE TWO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 11004

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		April 28 1983		9 <sup>10</sup> AM	
Cynthia E. Mc Kesey							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. BALTIMORE CITY OR COUNTY OF DEATH		
Female	Jamaican 2	May 21, 1912	70 YRS.		Montgomery County MD.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH		
Jamaica	Jamaica		Montgomery County		Olney		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS	
Montgomery General Hospital		Homemaker		At Home		14229 Pear Tree Lane 20906	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS			
Maryland	Montgomery	Silver Spring	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	14229 Pear Tree Lane 20906			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			
NORRIS		ALBERTHA		No			
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
Unknown		Beverly Mc Kesey, Dtr.,		14229 Pear Tree La. S. S., Md. 20906			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) GAS GANGRENE							< 12 HRS
0400 DUE TO, OR AS A CONSEQUENCE OF (b) CLOSURE DIAL MYONECROSIS							< 12 HRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
DUE TO, OR AS A CONSEQUENCE OF (c) DIABETIC KETOACIDOSIS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/28 1983 to 4/28 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.		22b. SIGNATURE		22c. ADDRESS		22d. DATE SIGNED	
		GEORGE J. SCHWEITZER, M.D.		Montgomery General Hospital, Olney, Md.		4/28/83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial		May 5, 1983		Jamaica		Kingston, Jamaica	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W.W. CHAMBERS CO., 8655 Ga. Ave. SS, Md. 20910		MAY 2 1983		John J. Canfield			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the funeral director, and the third copy should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 11B shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 1 0 0 5		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Raymond D. McMurray				2a. DATE OF DEATH MONTH DAY YEAR 4-7-83		2b. HOUR 0230 A M			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 2, 1927		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Shady Grove Adventist Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ATTORNEY		12b. KIND OF BUSINESS OR INDUSTRY SELF EMPLOYED	
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN POTOMAC		13d. STREET ADDRESS 11510 SPRING RIDGE RD. 20854			
14. FATHER'S NAME FIRST MIDDLE LAST RAYMOND ALLEN McMurray				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST IVY DOUGHTY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE YEAR OR DATES) YES		16b. SOCIAL SECURITY NO. WW 11 117-18-8425		17. INFORMANT ADDRESS SALLY K. McMurray, WIFE, POTOMAC, MD. 20854					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver & Kidney Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Colon Cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1539 days month									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4/6 1983, to 4/7 1983, that (I) (we) last saw the deceased alive on 4/6 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not, (they) did not view the body after death.)									
22b. SIGNATURE STEPHEN NEWMAN, M.D.				22c. DEGREE MD				22d. DATE SIGNED 4/7/83	
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS 19261 MONTGOMERY VILLAGE AVE. GAITHERSBURG					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 4/7/83		23c. NAME OF CEMETERY OR CREMATORY CEDAR HILL CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE SUITLAND PG. MD.			
24. FUNERAL DIRECTOR NAME RICHARD RAPP, INC. WASHINGTON, D.C. 20036				25a. DATE REC'D. BY REGISTRAR APR 11 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			



*Handwritten text, possibly a signature or name, appearing upside down.*

*Handwritten text, possibly a date or number, appearing upside down.*

APR 1 1983

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DEATH IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETURN PAGE 3 TO YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11006		
1. DECEASED NAME (TYPE OR PRINT) <b>Mary L Mellinger</b>										7a. DATE KNOWN OF DEATH ESTIMATED <b>4-2-83</b>		7b. HOUR <b>1 P.M.</b>
3. SEX <b>F</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH <b>7</b> DAY <b>21</b> YEAR <b>04</b>	6. AGE (IN YEARS) LAST BIRTHDAY <b>78</b> YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD MONTH <b>4</b> DAY <b>2</b> YEAR <b>83</b>	7d. HOUR <b>1 P.M.</b>					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery Co. MD.</b>						
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>9007 Mohawk Lane</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chief Operator</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>C&amp;P</b>				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Bethesda</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>9007 Mohawk Lane</b>		<b>20814</b>		
14. FATHER'S NAME FIRST <b>Eugene</b> MIDDLE LAST <b>Allison</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Hester</b> MIDDLE LAST <b>O'Neale</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>217-32-9484</b>		17. INFORMANT <b>Niece</b> ADDRESS <b>7120 Greentree Road Bethesda, Md. 20817</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> <b>4100</b> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .												
ACTUAL SIGNATURE <b>John S. Tauber</b>				TITLE (SPECIFY) _____ M.D. _____ MEDICAL EXAMINER				DATE SIGNED <b>4-2-83</b>				
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Tauber</b>				ADDRESS <b>8218 Wisconsin Ave</b>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 7, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Memorial Park</b>				23d. LOCATION CITY OR TOWN <b>Rockville</b> COUNTY <b>Maryland</b> STATE				
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b> ADDRESS <b>Funeral Homes, P.A., Bethesda, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 11 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John J. Garfield</b>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 3 1 1 0 0 7	
1 - STATE REGISTRAR				REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Gertrude A Melton</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4-5-83</b>		2b. HOUR <b>1:50 p.m.</b>
3. SEX <b>female</b>	4. RACE <b>white</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 13, 1898</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife (Ret)</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Maryland</b>		13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13c. STREET ADDRESS <b>5807 Cherry Wood Lane Apt. 103</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Westly Noel</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lecia Robertson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>579-26-3838</b>		17. INFORMANT ADDRESS <b>Fred S. Melton, Son, Apt. 103, Greenbelt, Md. 20770</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4292</b> IMMEDIATE CAUSE (a) <b>Acute Upper Gastrointestinal Bleeding</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Acute Aspiration Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Acute Cardopulmonary Arrest</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4-5-83</b> <b>4-5-83</b> <b>4-5-83</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>ASCVD, Senile Dementia, Cerebral Atrophy, Parkinson's Disease</b>					
19a. DATE OF OPERATION <b>None</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>No</b>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that <input checked="" type="checkbox"/> (the hospital) attended the deceased from <b>3-23-83</b> , 19____, to <b>4-5-83</b> , 19____, that <input checked="" type="checkbox"/> (myself) saw the deceased alive on <b>3-30-83</b> , 19____, and that in <input checked="" type="checkbox"/> (my) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) <input type="checkbox"/> (we) did not view the body after death.					
22b. SIGNATURE <b>MB Patrick III MD</b>		DEGREE		22c. DATE SIGNED <b>4-5-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G B Patrick III MD</b>		22e. ADDRESS <b>9221 Colesville Rd Silver Spring, Md 20910</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Apr. 8, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Washington National</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P. Co. Maryland</b>
24. FUNERAL DIRECTOR NAME <b>W.W. CHAMBERS CO., 517 11th St., S.E., Wash., D.C.</b>		ADDRESS		25a. DATE REC'D. BY REGISTRAR OF REGISTRAR'S SIGNATURE <b>APR 11 1983 John J. C... ..</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 3 1 1 0 0 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Doris Elizabeth Merritt			2a. DATE OF DEATH MONTH DAY YEAR April 5 1983		2b. HOUR 7 15 A.M.
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR October 29, 1919		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Kensington	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kensington Gardens Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. STATE Maryland		13b. COUNTY Prince Geo.	13c. CITY OR TOWN Colmar Manor	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 3415 41st Avenue 20722
14. FATHER'S NAME FIRST MIDDLE LAST JOHN A ROWE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN COFFERN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None 579-14-3087		17. INFORMANT ADDRESS Wayne C. Merritt, Husband Colmar Manor 3415 41st Avenue	
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Nephrotic Carcinoma of the Breast</u> 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>March 1</u> 19 <u>83</u> to <u>April 5</u> 19 <u>83</u> , that (I) (we) lost saw the deceased alive or obeyed (we) (did) and not saw the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE <u>W. W. Chambers</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-5-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. W. CHAMBERS		22e. ADDRESS 3700 Fairview Ave. Kensington, Md 20885			
23a. MANNER OF DEATH (SPECIFY) Burial		23b. DATE April 7, 1983	23c. NAME OF CEMETERY OR BURIAL PLACE Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P. G. Cty., Md.
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS		ADDRESS CO. 5801 Cleveland Ave.,		25. DATE REC'D. BY REGISTRAR APR 7 1983	

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ALMA C.E. MILLER</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 3 1983</b>			2b. HOUR <b>1:15 AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>February 1, 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>83</b> YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Australia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Australia</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.	
10. CITY OR TOWN OF DEATH <b>Silver Spring</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>608 Winona Court</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>William - Cox</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Winifred - Delohery</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>		16b. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT ADDRESS <b>Jean Hellfritzsch (Daughter) Same as # 13.</b>							

18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> <b>4140</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Atrial Fibrillation / Flutter</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 16</b> , 19 <b>79</b> , to <b>April 4</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>April 1</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>George A. Boivis M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/3/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>George A. Boivis M.D.</b>				22e. ADDRESS <b>5410 CONNORVILLE AVE NW D.C.</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>April 4/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland P.G. Co. Maryland</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Chambers Funeral Home Riverdale, Maryland</b>				APR 6 1983 REGISTRAR'S SIGNATURE <b>Paul J. Smith</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	3	1	1	0	1	0			
1. FOR STATE REGISTRAR										REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <b>EDA I MILLER</b>										2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
												4		2		83		8 <sup>05</sup> AM	
3. SEX <b>Female</b>			4. RACE <b>CAUCASIAN</b>			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS.				
						MONTH DAY YEAR <b>2 24 1917</b>			66			YRS			MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ohio</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County MD.</b>										
10. CITY OR TOWN OF DEATH <b>Rockville</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Lutheran Home</b>						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Government Employee</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Govt.</b>							
13a. STATE <b>Virginia</b>			13b. COUNTY <b>Fairfax Co.</b>			13c. CITY OR TOWN <b>Fairfax</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <b>10701 Main Street, 99999</b>							
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Dayton</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lydia Kihlken</b>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>					16b. SOCIAL SECURITY NO. <b>286-03-9952</b>					17. INFORMANT ADDRESS <b>Rev. Richard Reichard 9701 Veirs Dr. Rockville Md.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4140 Congestive Heart Failure, Effusive</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										DUE TO, OR AS A CONSEQUENCE OF (b) <b>AS H/D</b>									
										DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																			
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <b>Nov. 7, 1978</b> to <b>Apr. 1, 1983</b> that (I) (we) lost saw the deceased alive on <b>April 1, 1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE <b>Thomas E. Dooley MD</b>										DEGREE			22c. DATE SIGNED <b>April 2, 1983</b>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Thomas E. Dooley, M.D.</b>										22e. ADDRESS <b>2901 Olney-Sandy Springs Rd. Olney, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>					23b. DATE <b>April 5, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, Maryland</b>									
24. FUNERAL DIRECTOR NAME <b>The Hysong Company 1300 N St. N.W. Wash. D.C.</b>										25a. DATE REC'D. BY REGISTRAR <b>APR 11 1983</b>			25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>						



0.125

C.

580-3-85

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1. *Introduction*

2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 3 1 1 0 1 1	
1. FOR STATE REGISTRAR			CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST			MONTH DAY YEAR		HOUR	
John R miller			4-17-83		1453M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
male	caucasian	3-22-93	88 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	9. BALTIMORE CITY OR COUNTY OF DEATH				
Virginia	U.S.A.	Montgomery Co., MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Rockville	Shady Grove Adventist Hosp	Farmer				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Maryland	Montgomery	Dickerson	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	25141 Old Hundred Rd. 20842		
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
Thomas F. Miller	Ada Frances Sours		No			
16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
228079479		Mrs Ruth Woolwine,		P.O. Box 284, Clarksburg, Md. 20871		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) Congestive heart failure						6 mos
4140 DUE TO, OR AS A CONSEQUENCE OF						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
(b) Coronary Atherosclerosis						
DUE TO, OR AS A CONSEQUENCE OF						
(c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 4/17 1983 to 4/17 1983, that (I) (we) last saw the deceased alive on 4/17 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE		DEGREE		22c. DATE SIGNED		
Robert Millman		MD		4/17/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				
Robert Millman, MD		15 Cedar Park Dr Gaithersburg Md 20877				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Apr. 20, 1983	Germantown Baptist		Germantown, Montgomery, Md.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Orin L. Molesworth, P.A., Damascus, Md.		APR 20 1983		John J. Carver		

BP



CHILDREN

John R. Miller  
Wife Catherine  
Born 1888  
Age 35  
Occupation  
Address  
City  
State  
County  
Married  
Children

APR 20 1912  
RECEIVED  
CITY OF NEW YORK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

DHMH - 16 50M 1/81  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 1 2

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Raymond H. Miller		April 2, 1983		11:23AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
Male	White	June 17, 1908	74 YRS.	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Washington, D.C.	U.S.A.		Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Bethesda	Bethesda Retirement & Nursing Ho		Attorney		U.S. Gov't.
13a. STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS		
----	Wash, D.C.	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	3020 Oliver St., N.W. 99999		
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
George B. Miller		Sarah (unavailable)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
yes		WWII		Daughter-Marion M. Cronin - Same as #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY:					
IMMEDIATE CAUSE (a) CARDIAC ARREST					1 hour
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA Bladder with metastases					1+ year
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
		19 P.M.			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from MARCH 24, 19 83, to APRIL 2, 19 83, that (I) (we) last saw the deceased alive on MARCH 24, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. PHYSICIAN'S NAME (TYPE OR PRINT)		22c. ADDRESS		22d. DATE SIGNED	
Albert E. Marland Jr.		2737 DEVONSHIRE PL. N.W. WASH.D.C.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY	
Burial		April 6, 1983		Gate of Heaven Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE	
Silver Spring, Mont., Md.		APR 8 1983		John J. Carver	

MEDICAL CERTIFICATION

999999 BP

11-3A

April 1, 1953

Miller

H.

Rumor

June 14, 1951

White

White

Handwritten

U.S.A.

Washington, D.C.

Beethoven Retirement & Nursing H. Attn: Mrs. H. Attn: Mrs. H.

Beethoven

U.S. Capitol

x

Wash. D.C.

----

----

3050 Oliver St., N.W.

(unavailable)

Barth

Miller

B.

George

27-60-030 - Daughter-Martin M. Smith - same as 27-60-030

WWII

yes

Cost: \$100.00

Case record: 27-60-030 - same as 27-60-030

April 1, 1953 Date of Heaven Sem. Silver Service, Wash. D.C.

Level: Funeral Home

Washington, D.C.

Burial

*Robert M. ...*

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, THE MEDICAL EXAMINER SHOULD BE NOTIFIED. IF THE DEATH IS SUICIDE, THE MEDICAL EXAMINER SHOULD BE NOTIFIED. IF THE DEATH IS SUICIDE, THE MEDICAL EXAMINER SHOULD BE NOTIFIED. IF THE DEATH IS SUICIDE, THE MEDICAL EXAMINER SHOULD BE NOTIFIED.

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Paul THOMAS Morgan SR.</b>			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>4</b> DAY <b>27</b> YEAR <b>1983</b>		2b. HOUR <b>11:45</b> AM
3. SEX <b>M</b>	4. RACE <b>Cauc</b>	5. DATE OF BIRTH MONTH <b>3</b> DAY <b>5</b> YEAR <b>29</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>	IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>MACHINIST</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>NAVY DEPT.</b>	
13a. STATE <b>MD</b>		13b. CITY OR TOWN <b>MONTGOMERY KENSINGTON</b>		13c. STREET ADDRESS <b>20895 3009 EDGEWOOD RD</b>	
14. FATHER'S NAME FIRST <b>THOMAS</b> MIDDLE <b>DWIGHT</b> LAST <b>MORGAN</b>		15. MOTHER'S MAIDEN NAME FIRST <b>ANNE</b> MIDDLE <b>MAY</b> LAST <b>GREENING</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b>		16b. SOCIAL SECURITY NO. <b>161-22-4131</b>		17. INFORMANT <b>G. HELEN MORGAN</b> ADDRESS <b>SAME AS 13 WIFE</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIORESPIRATORY FAILURE</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CIRRHOSIS ESOPHAGEAL VARICES</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ETHANOLISM</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b> <b>1-2 YRS</b> <b>YRS</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION <b>4-12-83</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b>DENVER SHUNT</b>			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>4 26 1983 P.M.</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>COLLAPSED AT HOME</b>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>HOME</b>		21f. LOCATION STREET <b>3009 EDGEWOOD RD</b> CITY OR TOWN <b>KENSINGTON</b> COUNTY <b>MONT</b> STATE <b>MD</b>	
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Francis C Mayle</b>		TITLE (SPECIFY) <b>Sgt</b>		DATE SIGNED <b>4/27/83</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C Mayle</b>		ADDRESS <b>8200 Wisconsin Ave Bethesda MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>		23b. DATE <b>4/30/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GATE OF HEAVEN</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS J. COLLINS</b>		24b. ADDRESS <b>500 UNIV. BLVD. W. SILVER SPRING, MD. 20901</b>		25a. DATE REC'D. BY REGISTRAR <b>MAY 2 1983</b>	
25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>		25c. DATE REC'D. BY REGISTRAR <b>MAY 2 1983</b>			

MEDICAL CERTIFICATION

100-100000-100000

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF CHURCH AND CHAPLAIN

(M)

STATION FILED

NOV 10 1944

100-100000-100000



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN COPIES OF PAGES 1, 2, AND 3 WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH			MONTH DAY YEAR			2b. HOUR			
Keysha K. Morris						4 22 19 83						M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		2d. HOUR	
Female		White		Feb 18, 1983		YRS. 2 4		MONTHS 2 4		HOURS MIN		4 22 19 83		3:53 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
Washington, D. C.				U.S.A.								Montgomery County, MD.			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
Silver Spring				2535 Glen Allen Avenue				N/A							
13a. STATE				13b. COUNTY				13c. CITY OR TOWN				13d. INSIDE CITY LIMITS?			
Maryland				Montgomery				Silver Spring				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				13e. STREET ADDRESS							
George S. Morris				Kathleen Tavenner				2535 Glen Allen Ave. 20906							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS			
No				N/A				George S. Morris				Same as 13 Father			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
				P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION							
								CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held on, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED							
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS											
Thomas D. Smith, M.D.				111 Penn St. Balto, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				4/26/83				Gate of Heaven Cemetery				Silver Spring Mont Md			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Francis J. Collins				APR 28 1983				John J. Conner							
500 Univ. Blvd., W., Silver Spring, Md. 20901															

TO THE DIRECTOR, BUREAU OF PLANT INDUSTRY  
FROM THE CHIEF, BUREAU OF PLANT INDUSTRY  
SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]



BP \_\_\_\_\_  
DHMH - 16 50M 4/82  
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				83 11015 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>Judith Mrazik</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>April 23 1983</b>				2b. HOUR <b>7:48<sup>AM</sup></b>	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 31, 1937</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Rockville</b>		13e. STREET ADDRESS <b>13210 Twinbrook Parkway (20851)</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Randolph Crockett</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Dorothy Prentiss</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>219-34-7550</b>		17. INFORMANT ADDRESS <b>Frank S. Mrazik (husband) Same as 13</b>					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <b>2030 IMMEDIATE CAUSE (a) MULTIPLE MYELOMA</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 YEARS</b>	
DUE TO, OR AS A CONSEQUENCE OF (b) _____									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <del>Mr</del> (this hospital) attended the deceased from <b>19 83</b> , to <b>APRIL 23, 19 83</b> , that <del>Mr</del> (we) lost saw the deceased alive on <b>APRIL 23, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>Eugene P. Flannery</b>				DEGREE <b>MD</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>4/23/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>EUGENE P. FLANNERY</b>				22e. ADDRESS <b>18111 PRINCE PHILIP DR. OLNEY, MO- 20832</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Removal</b>		23b. DATE <b>Apr. 23, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Uniformed Services University of Health Sciences</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bethesda, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Capitol Funeral Service, Falls Church, Va.</b>				25a. DATE RECD. BY <b>APR 28 1983</b>		25b. SIGNATURE <b>John J. Cough</b>			



Remove

Vol. 33, 1983 Multilingual ed. of Berlin

CHIEF

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND - 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 11016	
1. DECEASED NAME (TYPE OR PRINT) <b>RAFAEL ALCIDES MURCIA</b>							2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> <b>4-8-83</b> 19		2b. HOUR M <b>12:20</b>		
3. SEX <b>MALE</b>		4. RACE <b>HISPANIC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>NOVEMBER 19, 57 25RS.</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>25RS.</b>		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD <b>4-8-83</b> 19	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>ELSAVADOR</b>			7b. CITIZEN OF WHAT COUNTRY? <b>ELSAVADOR</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Eastbound lane of 495 W. of</b>					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>New Hampshire Avenue</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>PRINCE GEORGES</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>2254 HANON STREET</b> 20783		
14. FATHER'S NAME FIRST MIDDLE LAST <b>JUVENICIO MURCIA</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>LAONILDA BLANCO</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>NO</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>UNKNOWN</b>			17. INFORMANT ADDRESS <b>(BROTHER) JULIO BLANCO SAME AS 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: <b>8147</b> IMMEDIATE CAUSE (a) <b>Multiple injuries</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>DUE TO, OR AS A CONSEQUENCE OF</b> (c) <b>DUE TO, OR AS A CONSEQUENCE OF</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY <b>12:15AM</b> MONTH DAY YEAR <b>4-8-83</b> P.M.				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>pedestrian struck by auto(s)</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>hwy.</b>				21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>eastbound Lane of 495 Rockville, Maryland</b>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) M.D. <b>Assistant</b>				DATE <b>4-8-83</b> SIGNED			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn Street</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>			23b. DATE <b>APRIL 12, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>GEORGE WASHINGTON</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>ADELPHIA, MARYLAND</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>VANN &amp; WILLIAMS FUNERAL HOME 4804 GA. AVE. n.w.</b>						25a. DATE REC'D. BY REGISTRAR <b>APR 14 1983</b>		25b. REGISTRAR'S SIGNATURE <i>Frank J. Canine</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										83 11017		
1. FOR STATE REGISTRAR			REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Edward T Muir						4/7/83			11 P M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Caucasian		11 9 98		84 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Wash., D.C.		U.S.A.				Montgomery MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Fernwood Nursing Home				Int. Rev. Srvc.			Retired			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
D.C.				Washington				5425 Conn. Ave. NW #319 20015				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Edward Muir				Dora Knight								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No		214-09-3392		Jean Muir		11933 Waterway Drive Rockville, Maryland 20853						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) 4149 Cardio Respiratory Arrest												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart disease												
(c) Generalized Arteriosclerosis												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
			P.M. 19									
21d. INJURY OCCURRED: WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22. I certify that (1) (this hospital) attended the deceased from 2/9 1983 to 4/7 1983, that (1) (me) last saw the deceased alive on 2/9 1983 and that in (my) opinion death occurred on the date and hour and from the causes stated above. (If (a) (b) (c) view the body after death.)												
22a. SIGNATURE J. Blaine Fitzgerald					DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/8/83.			
22b. PHYSICIAN'S NAME (TYPE OR PRINT)					22d. ADDRESS							
J. Blaine Fitzgerald					8218 Wisconsin Ave. Bethesda, Md. 20814							
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE				
Removal			4/8/1983		Geo. Wash. Med. School			Washington, D.C.				
24. FUNERAL DIRECTOR Columbia Mortuary Services, Inc. 225 Missouri Ave. NW Washington, D.C. 20011						25a. DATE REC'D. BY REGISTRAR APR 12 1983 REGISTRAR'S SIGNATURE John J. Canine						



WASHINGTON, D.C.

Montgomery

KX

U.S.A.

Wash., D.C.

Int. Rev. Serv. Bureau

Termwood Building House

Rechnung

2222 Conn. Ave. NW WASH DC 20037

KX

Washington

D.C.

Post Office

Edward Blair

1033 Webster Drive  
Rockville, Md 20853

Learn Mail

21-00-3332

No

2222 Wisconsin Ave. Bethesda, Md. 20814

J. Blaine Fitzgerald

Washington, D.C.

Geo. Wash. Sch. School

11/8/1983

Renovated

Columbia County Services, Inc.

222 Wisconsin Ave. NW Washington, D.C. 20011

FOR  
1. STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ROLAND W. NEAL</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>04 01 83</b>		2b. HOUR <b>11:41 PM</b>	
3. SEX <b>Male (Male)</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>8 5 97</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH <b>Rockville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hosp</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
12a. USUAL OCCUPATION (TYPE OF WORK, FOR MOST OF WORKING LIFE) <b>Retired - Insurance Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>Md</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>	
13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>403 Russell Ave</b>		13f. APT. NO. <b>(20877)</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>W. Roland Neal</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Bessie M. Booth</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>Yes WW 1</b>		16b. SOCIAL SECURITY NO. <b>216-10-0238</b>		17. INFORMANT <b>William W. Neal</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: <b>4149</b> IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CORONARY ARTERY DISEASE</b> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 min</b> <b>5 yrs</b>		PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Chronic Obstructive Pulmonary Disease</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <b>3/21</b> , 19 <b>83</b> , to <b>4/1</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>4/1</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.		22b. DATE SIGNED <b>4/2/83</b>	
22a. SIGNATURE <b>Carl I. Schoenberger</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/2/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>CARL I. SCHOENBERGER</b>		22e. ADDRESS <b>4701 Randolph Rd Rockville MD</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/5/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cemetery</b>	
23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore Md</b>		24. FUNERAL DIRECTOR NAME <b>Witzke, P.A.</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 4 1983</b>	
25b. GISTRAR'S SIGNATURE <b>John J. Carver</b>		25c. ADDRESS <b>1630 Edmondson Avenue Catonsville, Md. 21228</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



11/12/83



APR 4 1983

Chief, Submarine  
Mr. [illegible]  
4/12/83

Chief, Patrol Division  
2 [illegible]

USA  
[illegible]  
[illegible]

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 1 9

FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Aspasia Nitsios</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>4 - 2 - 83</b>			2b. HOUR <b>7 30 AM</b>	
3 SEX <b>Female</b>		4 RACE <b>Greek</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>4 25 00</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
10. CITY OR TOWN OF DEATH <b>Kensington</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Kensington Gardens Nsg</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>Mont.</b>		13c. CITY OR TOWN <b>S.S.</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Harazambos</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth Manasos</b>		13e. STREET ADDRESS <b>20910 9416 Woodland Drive</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>None</b>		16b. SOCIAL SECURITY NO. <b>578 01 5722</b>		17. INFORMANT <b>Helen Perantonakis (Daughter)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Recurrent Aneurysm</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Dissection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>2500</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 hrs</b> <b>15 yr</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>Tuberculosis; Heart Failure</b>							
19a. DATE OF OPERATION <b>-</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>3/88</b> , 19 <b>83</b> , to <b>4/2/83</b> , 19 <b>83</b> , that (I) <del>was</del> lost saw the deceased alive on <b>4/1</b> , 19 <b>83</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> (did not) view the body after death.							
22b. SIGNATURE <b>John J. Goff</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>4/2/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>R. Goff</b>				22e. ADDRESS <b>10620 Baltimore S.S. Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/4/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ftlincoln Cemetery Brentwood PG Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME ADDRESS <b>Hines/Rinaldi 11800 N.H.Ave.S.S.Md.</b>				25a. DATE REC'D. BY REGISTRAR (S) REGISTRAR'S SIGNATURE <b>APR 6 1983 John J. Goff</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and that it be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 911.

BP \_\_\_\_\_



20% COTTON  
CHIEF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 3 1 1 0 2 0	
1. FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) James J. Nix						2a. DATE OF DEATH MONTH DAY YEAR APRIL 14, 1983				2b. HOUR 7:40P M.	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 8 8 35		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Fireman		12b. KIND OF BUSINESS OR INDUSTRY D.C.			
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4505 Gridley Road 20906			
14. FATHER'S NAME FIRST MIDDLE LAST Joseph G. Nix				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary C. Cook							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1953-1957 577-46-2527		17. INFORMANT Emily M. Nix				ADDRESS Same as 13 Wife			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARRHYTHMIA</u> 3989 DUE TO, OR AS A CONSEQUENCE OF <u>Heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>RHD &amp; ASHD</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>yes -</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>onto-ch</u> 30y	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension, Angioplasty old &amp; new</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 12</u> , 19 <u>68</u> , to <u>April</u> , 19 <u>83</u> , that (I) <del>lost</del> saw the deceased alive on <u>Marc h 14</u> , 19 <u>83</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above. <del>(I) (we) (did not) view the body after death.</del>											
22b. SIGNATURE <i>John S. Saia</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/15/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John S. Saia, M.D.						22e. ADDRESS 809 Veirs Mill Rd. Rockville, MD 20851					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4/18/83		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pri. Geo. Md.					
24. FUNERAL DIRECTOR NAME Francis J. Collins						ADDRESS 500 Univ. Blvd., W., Silver Spring, Md. 20901		25. RECEIVED BY REGISTRAR APR 21 1983			
						REGISTRAR'S SIGNATURE <i>John J. Canfield</i>					

BP

4-20-67



Handwritten notes on the left margin, including "10-10-67" and "10-10-67".

Vertical text on the left side, possibly "10-10-67" repeated.

Handwritten text in the center, possibly "10-10-67" and "10-10-67".

Handwritten text in the center, possibly "10-10-67" and "10-10-67".

Handwritten signature or initials in the lower right area.

APR 21 1967



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 AND 2 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

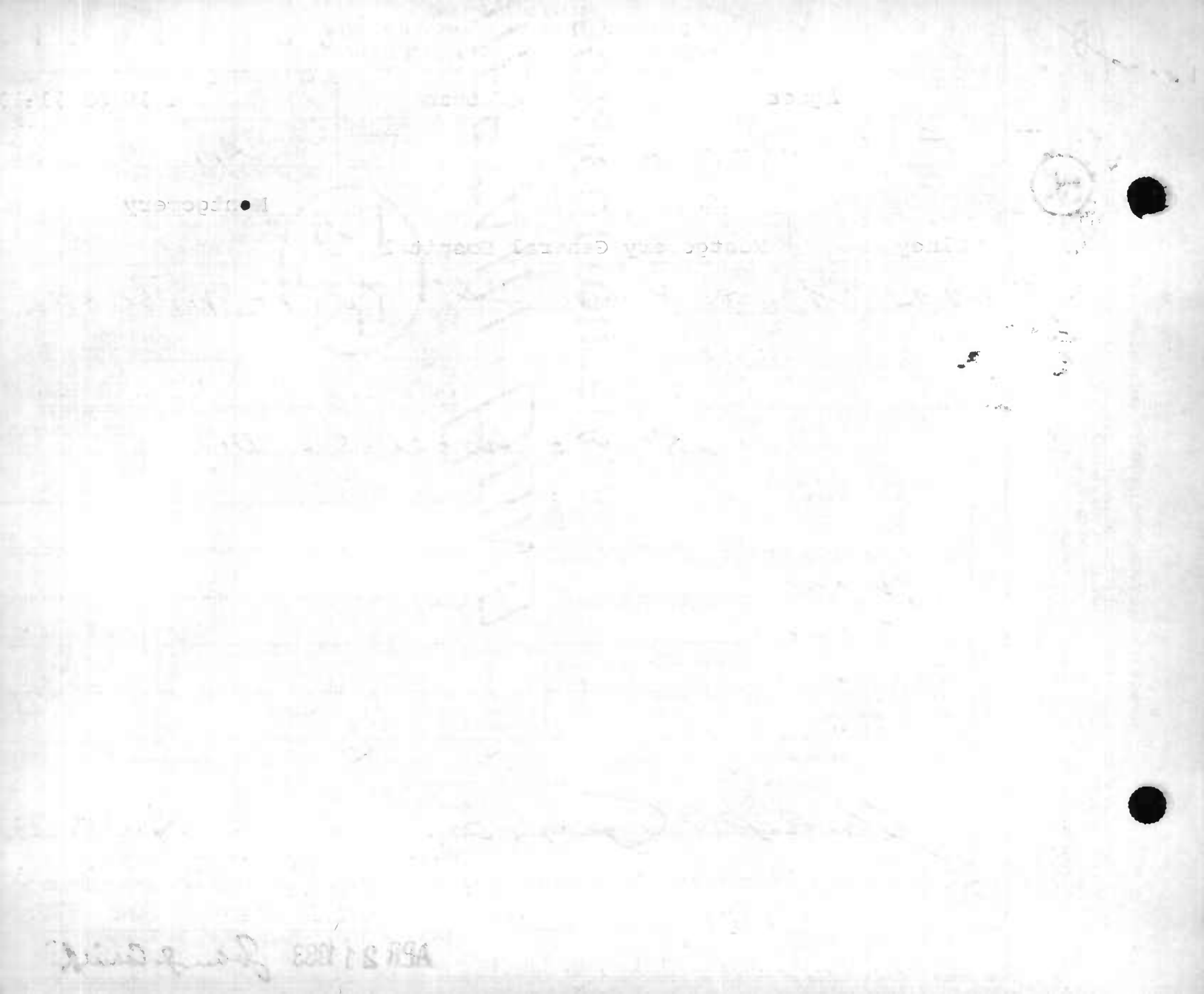
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DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		4 18 83		11:11 PM	
Agnes Frances Noonan							
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD	2d. HOUR
F	W	Sept. 14, 24	58 YRS.	MONTHS DAYS HOURS MIN.		April 18, 83	11:14 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
SOUTH CAROLINA	U.S.A.				Montgomery MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney	Montgomery General Hospital			MEDICAL SECRETARY			
13a. STATE	13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS		20853		
MD	Mont. Rockville	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	5120 Norbeck Rd				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
FIRST MIDDLE LAST		FIRST MIDDLE LAST					
JOHN J. MILLS		MARY CONNELLY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
NO		073-18-8443		RICHARD J. NOONAN		SAME AS 13 HUSBAND	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Acute Myocardial Dis</u>							
4291							
DUE TO, OR AS A CONSEQUENCE OF							
(b)							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
None						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .							
ACTUAL SIGNATURE		TITLE (SPECIFY)		MEDICAL EXAMINER		DATE	
<u>John S. Rogers</u>		M.D.		Daps		April 19, 1983	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
JOHN S. ROGERS		1919 SEMINARY ROAD,		SILVER SPRING, MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY STATE	
BURIAL	4/21/83	GATE OF HEAVEN		SILVER SPRING		MONT MD.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
NAME ADDRESS		APR 21 1983		<u>John J. Connelly</u>			
500 UNIV. BLVD., W., SILVER SPRING, MD. 20901							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 3 1 1 0 2 2	
1- FOR STATE REGISTRAR					CERTIFICATE OF DEATH					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Lettie Norris					2a. DATE OF DEATH MONTH DAY YEAR 4 24 83		2b. HOUR 5:20 am				
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10 22 97		6. AGE (IN YEARS LAST BIRTHDAY) 85 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery City MD.					
10. CITY OR TOWN OF DEATH Rockville, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Collingswood Ng Ctr.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) nurses aide		12b. KIND OF BUSINESS OR INDUSTRY hospital			
13a. STATE Md.		13b. COUNTY Fred.		13c. CITY OR TOWN Middletown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1717 Marker Rd.		21769	
14. FATHER'S NAME FIRST MIDDLE LAST HENRY A. NORRIS					15. MOTHER'S MAIDEN NAME FIRST MIDDLE MARY MENTZER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 218-30-0205		17. INFORMANT Henry J. Norris		ADDRESS Silver Spring, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4370 IMMEDIATE CAUSE (a) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO-SCLEROTIC CEREBRO DUE TO, OR AS A CONSEQUENCE OF VASCULAR DISEASE (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MO 2 YEARS	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from JULY 1981, to 24 APR 1983, that (I) (we) last saw the deceased alive on 18 APR 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)											
22b. SIGNATURE Walter E. Goetz MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 24 APR 83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WALTER E. GOETZ MD						22e. ADDRESS 2309 SHOREFIELD RD WHEATON MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE Apr. 27, 1983		23c. NAME OF CEMETERY OR CREMATORY Lutheran Cem.		23d. LOCATION Middletown Fred. Md. STATE			
24. FUNERAL DIRECTOR NAME Thompson Funeral Home						25. DATE REC'D. BY REGISTRAR MAY 2 1983		26. REGISTRAR'S SIGNATURE John J. Carver			

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 0 2 3 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) <b>M. Adelaide Oberholtzer</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>4 28 83</b>				2b. HOUR <b>4:00AM</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 17 1900</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.			
10. CITY OR TOWN OF DEATH <b>Olney</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <b>Montgomery General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Sect. Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>US Govt.</b>	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>403 Russell Avenue 20877</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Gaithersburg</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Jacob Thomas</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ada Elizabeth Thomas</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>577-30-5070A</b>		17. INFORMANT <b>Raymond M. Oberholtzer-husband-(same as 13e)</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>4140</b> IMMEDIATE CAUSE (a) <b>Coronary Heart Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>A.S.H.D</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Months</b> <b>Years</b>									
PART 2. OTHER DECEASED CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Chronic renal disease</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>19 77</b> to <b>4-28 83</b> , that (I/we) last saw the deceased alive on <b>4-27 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Jack Schumacher, MD</b>				DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4-28-83</b>			
22d. ADDRESS <b>105 Russell Ave., Gaithersburg, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>5-2-1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olivet Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Frederick Frederick Md.</b>			
24. FUNERAL DIRECTOR <b>Hines/Rinaldi Funeral Home</b>				11800 N.H. Ave., Silver Spring, Md.		25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b> REGISTRAR'S SIGNATURE <b>John J. Carver</b>			

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W. H. & C. O. 100

Dr. Mayle, ME. Notified &amp; approved

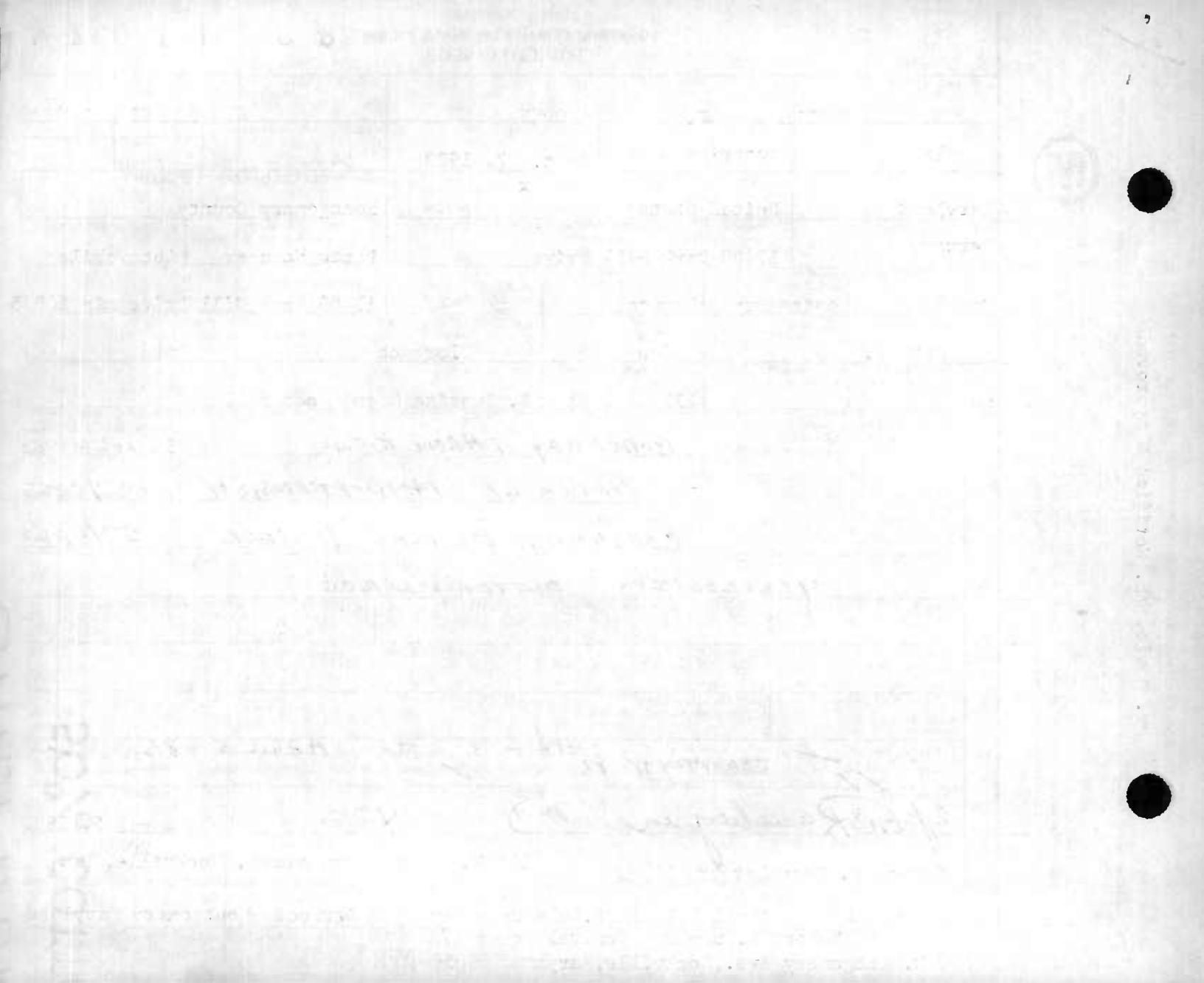
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 12 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 1 0 2 4	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>PORTER E. ODEN</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>4 5 83</b>			2b. HOUR <b>3 AM</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 7, 1928</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Derwood</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>17409 Park Mill Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Parts Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Automobile</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b>					13b. CITY OR TOWN <b>Derwood</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>17409 Park Mill Drive zip 20855</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>John W. Oden</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Ward</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>212 24 3821</b>		17. INFORMANT <b>G. Juanita Oden</b>				ADDRESS <b>see # 13</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY THROMBOSIS</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ARTERIAL HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY DISEASE</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Several Hours</b> <b>10 years</b> <b>5 years</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <b>GENERALIZED ARTERIOSCLEROSIS</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 13, 1983</b> to <b>APRIL 5, 1983</b> that (I) (we) saw the deceased alive on <b>JANUARY 18, 1983</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (you) (did not) view the body after death.											
22b. SIGNATURE <b>Gordon S. Rosenberger</b> M.D.					DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>April 5, 1983</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Gordon S. Rosenberger, MD</b>					22e. ADDRESS <b>310 W. Montgomery Avenue, Rockville, Md. 20850</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>April 9, 1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Luke Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Derwood Montgomery Maryland</b>					
24. FUNERAL DIRECTOR NAME <b>Robert A. Pumphrey</b>						ADDRESS <b>Funeral Homes P/A</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b>			
25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>						25c. ADDRESS <b>300 W. Montgomery Ave., Rockville, Maryland 20850</b>					

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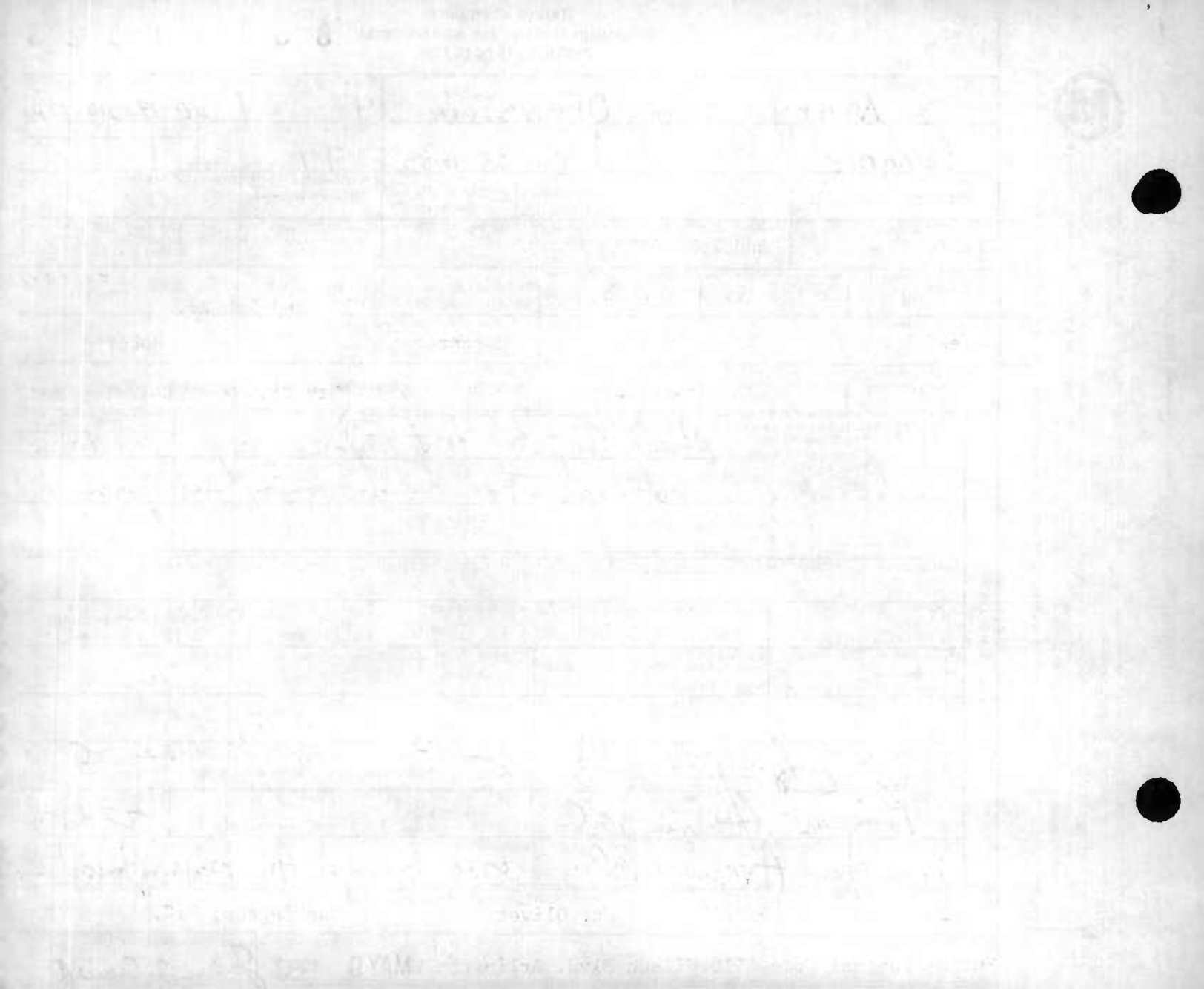


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 3 1 1 0 2 5	
1. FOR STATE REGISTRAR					REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Ellen OFENSTEIN					2a. DATE OF DEATH MONTH DAY YEAR 4 4 30 1983		2b. HOUR 10:30 AM				
3. SEX Female		4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR 8 25 1985		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 97		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.					
10. CITY OR TOWN OF DEATH Wheaton		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS CITY, GIVE STREET ADDRESS) Randolph Hill				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. CITY OR TOWN Montgomery		13c. CITY OR TOWN Wheaton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Jeremiah O'Connell					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Robert					13e. STREET ADDRESS 4011 Randolph Rd. 20902	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 578-46-9514		17. INFORMANT ADDRESS Sue Denny 4535 48th St. NW Washington, D.C.							
18. CAUSE OF DEATH (Enter only one cause per part (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Acute Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 Hours											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from March 29, 1983, to April 30, 1983, that (I) (we) lost saw the deceased alive on April 29, 1983, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above (the we) (did) (did not) view the body after death.											
22b. SIGNATURE Benjamin H. Aronson, MD.			DEGREE			22c. DATE SIGNED 43053					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Benjamin H. Aronson, MD.			22e. ADDRESS 3720 Fremont Ave. Kensington, Md. 20745			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 5/3/83		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet			23d. LOCATION CITY OR TOWN COUNTY STATE Washington, D.C.			
24. FUNERAL DIRECTOR NAME Murphy Funeral Home 4510 Wilson Blvd. Arlington, VA						25a. DATE REC'D. BY REGISTRAR MAY 9 1983		25b. REGISTRAR'S SIGNATURE Joan J. Carver			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be contacted.

FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 2 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <u>JAMES L. PADGETT</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>4/30/83</u>			2b. HOUR <u>6 P.M.</u>			
3 SEX <u>MALE</u>		4 RACE <u>CAUCASIAN</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>7 25 89</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>84</u> YRS		7. UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>WASH D.C.</u>		9. CITIZEN OF WHAT COUNTRY? <u>USA</u>		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH <u>MONTGOMERY CO.</u> MD.			
12. CITY OR TOWN OF DEATH <u>Silver Spring</u>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Chief Clerk Railroad</u>		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <u>MARYLAND</u>		17. COUNTY <u>Montgomery</u>		18. CITY OR TOWN <u>Silver Sp.</u>		19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. STREET ADDRESS <u>15311 BEAVERBROOK CT</u>	
21. FATHER'S NAME FIRST MIDDLE LAST <u>PADGETT</u>		22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>EMMA</u>		23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>		24. SOCIAL SECURITY NO. <u>NONE</u>		25. INFORMANT ADDRESS <u>Helen Padgett see 13 E</u>	
26. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: <u>4349</u> IMMEDIATE CAUSE (a) <u>Cerebral Infarct in Right</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral artery sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized Arteriosclerosis</u> APPROPRIATE INTERVAL BETWEEN INFARCT AND DEATH <u>12 days</u> <u>3 mos</u> <u>15 yrs</u>									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <u>Arteriosclerosis heart disease</u>									
27a. DATE OF OPERATION <u>9/9</u>		27b. CONDITION FOR WHICH OPERATION WAS PERFORMED				28a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		28b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
29a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		29b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		29c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
30a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		30b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		30c. LOCATION STREET CITY OR TOWN COUNTY STATE					
31. I certify that (I) (this hospital) attended the deceased from <u>77</u> to <u>30 April</u> 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>30 April</u> 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
32a. SIGNATURE <u>Merton L. White M.D.</u>		32b. DEGREE <u>M.D.</u>		32c. DATE SIGNED <u>30 April 83</u>				32d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
33a. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Merton L. White M.D.</u>		33b. ADDRESS <u>9911 Georgia Ave Silver Spring Md 20902</u>		34. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>					
35a. DATE <u>5-2-83</u>		35b. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>		35c. LOCATION CITY OR TOWN COUNTY STATE <u>Silver Spring Montgomery P.G. Maryland</u>					
36. FUNERAL DIRECTOR NAME <u>W.L. Chambers</u>		36b. ADDRESS <u>8605 Georgia Ave Silver Spring Md</u>		37. DATE REC'D. BY REGISTRAR <u>MAY 3 1983</u>		38. REGISTRAR'S SIGNATURE <u>John J. Carter</u>			



UNITED STATES  
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		8 3 1 1 0 2 7		REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Louis N Palder						2a. DATE OF DEATH MONTH DAY YEAR 4 25 83		2b. HOUR 6 P M	
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5 1 98		6. AGE (IN YEARS LAST BIRTHDAY) 84		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.			
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner (Ret.) Tire Sales		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE md		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1131 Univ. Blvd H 807	
14. FATHER'S NAME FIRST MIDDLE LAST Simcha		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sarah (unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-48-9817		17. INFORMANT Bethesda, Md. Cynthia Zabrek; 7420 Westlake Terr.					
18. CAUSE OF DEATH (Enter only one cause per line in 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Rpt. aneurysm cerebral artery DUE TO, OR AS A CONSEQUENCE OF (b) Thrombosis of left coronary artery DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic cardiovascular disease years APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 days									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Obstructive coronary artery disease + chronic obstructive pulmonary disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 4-25-83 to 4-25-83, that (I) (we) lost saw the deceased alive on 4-25-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.									
22b. SIGNATURE Jason Geiger, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4-26-83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JASON GEIGER, M.D.		22e. ADDRESS 8830 CAMERON STREET SILVER SPRING, MD 20910							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-28-1983		23c. NAME OF CEMETERY OR CREMATORY Mt. Lebanon Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Hyattsville Maryland			
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels; 1170 Rockville Pike		24b. ADDRESS Rockville, Md.		25a. DATE REC'D BY REGISTRAR (IN REGISTRAR'S OFFICE) APR 29 1983					





TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH THE DEATH CERTIFICATE. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGE 4 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										8 3 1 1 0 2 8									
1. DECEASED NAME (TYPE OR PRINT) <b>Charles Palmer</b>										2a. DATE KNOWN OF DEATH MONTH <b>4</b> DAY <b>8</b> YEAR <b>1983</b>									
3. SEX <b>Male</b>		4. RACE <b>Black</b>		5. DATE OF BIRTH MONTH <b>Jul.</b> DAY <b>7</b> YEAR <b>1922</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>60</b> YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH <b>4</b> DAY <b>8</b> YEAR <b>1983</b>		2b. HOUR <b>11:30</b> P. M.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.							
1d. CITY OR TOWN OF DEATH <b>Silver Spring</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1 Manchester Place, #102</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Laborer (retired)</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>W.S.S.C.</b>							
13a. STATE <b>Maryland</b>				13b. COUNTY <b>Montgomery</b>		13c. CITY OR TOWN <b>Silver Spring</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1 Manchester Place, #102</b>									
14. FATHER'S NAME FIRST <b>Harry</b> MIDDLE <b>Palmer</b> LAST										15. MOTHER'S MAIDEN NAME FIRST <b>Louise</b> MIDDLE <b>Campbell</b> LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS <b>Silver Spring, Md. 20910</b> <b>Betty Macgruder (8904 Manchester Rd.)</b>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>carcinoma of the esophagus.</b> DUE TO, OR AS A CONSEQUENCE OF (c)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>None</b>																			
19a. DATE OF OPERATION <b>None</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <b>None</b>											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) <b>Deputy</b> MEDICAL EXAMINER <b>1919 Seminary Road</b> <b>Silver Spring, Montgomery, Md.</b>								DATE SIGNED <b>4/11/83</b>							
EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>4-14-83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lincoln Park Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Rockville, Montg.</b> COUNTY <b>Md.</b> STATE									
24. FUNERAL DIRECTOR NAME <b>George R. Snowden</b>				ADDRESS <b>246 N. Washington St. Rockville, Md. 20850</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b> REGISTRAR'S SIGNATURE <i>John J. Cahill</i>											

Report of the  
Special Agent in Charge  
of the  
Bureau of Plant Industry  
for the  
Year 1917

During the year 1917, the Bureau of Plant Industry has been engaged in a number of important projects, including the investigation of the causes of the recent outbreaks of the Colorado potato beetle and the European spruce sawfly.

The investigation of the Colorado potato beetle has been continued, and it has been found that the beetle is a pest of the potato in many sections of the country. It is now necessary to take prompt action to prevent the spread of the beetle to other sections.

The investigation of the European spruce sawfly has also been continued, and it has been found that the sawfly is a pest of the spruce in many sections of the country. It is now necessary to take prompt action to prevent the spread of the sawfly to other sections.

In addition to the investigation of the Colorado potato beetle and the European spruce sawfly, the Bureau has also been engaged in a number of other projects, including the investigation of the causes of the recent outbreaks of the European spruce sawfly and the Colorado potato beetle.

The investigation of the European spruce sawfly has been continued, and it has been found that the sawfly is a pest of the spruce in many sections of the country. It is now necessary to take prompt action to prevent the spread of the sawfly to other sections.

The investigation of the Colorado potato beetle has also been continued, and it has been found that the beetle is a pest of the potato in many sections of the country. It is now necessary to take prompt action to prevent the spread of the beetle to other sections.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item #15&23b per phone call w/Fun. STATE OF MARYLAND  
FOR Home 4/18/83 rc DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
1- STATE REGISTRAR CERTIFICATE OF DEATH 8 3 1 1 0 2 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Dorothy Diller Paradis</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>April 11, 1983</b>		2b. HOUR <b>1:40 p.m.</b>
3. SEX <b>FEMALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>MARCH 9, 1902</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>81</b>	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>PENN.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.		
10. CITY OR TOWN OF DEATH <b>Olney</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Montgomery General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>Law Firm</b>	
13a. STATE <b>Penn.</b>		13b. COUNTY <b>Chester</b>	13c. CITY OR TOWN <b>Glen Moore</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>Rt. #1 Iron Bridge Rd.</b>
14. FATHER'S NAME FIRST MIDDLE LAST <b>William Walter Diller</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Caroline Miller</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>no</b>		16b. SOCIAL SECURITY NO. <b>159-03-1154</b>		17. INFORMANT ADDRESS <b>Donna Paradis Same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <b>4100</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Ulcerative Colitis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <del>the hospital</del> attended the deceased from <b>April 8</b> , 19 <b>83</b> , to <b>April 11</b> , 19 <b>83</b> , that (I) <del>the</del> last saw the deceased alive on <b>April 11</b> , 19 <b>83</b> , and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>did</del> (did not) view the body after death.					
22b. SIGNATURE <b>Barry Hecht</b>		DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/11/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Barry Hecht, M.D.</b>		22e. ADDRESS <b>3929 FERRARA DRIVE WHEATON, MARYLAND 20906</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>BURIAL</b>	23b. DATE <b>APR. 14, 1983</b>	23c. NAME OF CEMETERY OR CREMATORY <b>W. Laurel Hill Cem.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Bala-Cynwyd Mont. Penn.</b>	
24. FUNERAL DIRECTOR NAME <b>FRANCIS H. BARBER</b>		ADDRESS <b>LAYTONSVILLE, MD. 20879</b>		25a. DATE REC'D. BY REGISTRAR <b>APR 14 1983</b>	25b. REGISTRAR'S SIGNATURE <b>Barry J. Connel</b>



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL EXAMINER. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. IF THE DEATH OCCURS AT HOME, THE MEDICAL EXAMINER SHOULD BE CALLED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17  
(VR A15 ME (5))  
15M 7/77

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Grace Olive Pariseau			2a. DATE KNOWN OF DEATH ESTIMATED April 10, 1983			2b. HOUR 1:45 A.M.		
3. SEX Female	4. RACE Caucasian	5. DATE OF BIRTH MONTH DAY YEAR Jan 22 1925	6. AGE (IN YEARS) LAST BIRTHDAY 96 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD April 10, 1983	7d. HOUR 1:45 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.		
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 15100 Glade Drive Apartment 2 C				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland			13b. CITY OR TOWN Montgomery		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 20906 15100 Glade Drive Apartment 2 C		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Neal Preble			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Letitia Whitten					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-09-1225		17. INFORMANT (Daughter) ADDRESS Pauline P. Culver, Silver Spring, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial D.I.S.</u> 4291 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Chronic Obstructive Pul.D.I.S.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Yrs</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? None					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John S. Rogers</i>				TITLE (SPECIFY) M.D. <i>Dep.</i>		DATE SIGNED April 10, 1983		
EXAMINER'S NAME (TYPE OR PRINT) John S. Rogers M.D.				ADDRESS 1919 Seminary Road, Silver Spring, MD				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE April 11, 1983		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria Virginia		
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland				25a. DATE REC'D. BY REGISTRAR APR 13 1983		25b. REGISTRAR'S SIGNATURE <i>John J. ...</i>		

RECEIVED  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON, D.C.



TO THE SECRETARY OF THE NAVY  
WASHINGTON, D.C.



RECEIVED  
OFFICE OF THE  
SECRETARY OF THE  
NAVY  
WASHINGTON, D.C.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clarence Russell Parkin					2a. DATE OF DEATH MONTH DAY YEAR April 23, 1983					2b. HOUR 1:30p M	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR May 18, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 75		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Missouri		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County MD.					
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Fernwood Nursing Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Architect		12b. KIND OF BUSINESS OR INDUSTRY Navy Dept.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8620 Melwood Road 20817			
14. FATHER'S NAME FIRST MIDDLE LAST Christopher Douglas Parkin				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Estelle Roberts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 578-36-0770		17. INFORMANT Rosemary G. Parkin Wife same as 13e					
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF <u>Acute Cardiac Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> (b) <u>Arteriosclerotic Heart disease</u> <u>2 months</u> (c) <u>Alzheimers disease</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alzheimers disease</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>5/6</u> 19 <u>68</u> to <u>4/23</u> 19 <u>83</u> , that (I) <del>was</del> last saw the deceased alive on <u>4/20</u> 19 <u>83</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above. (If deceased did not view the body after death.)											
22b. SIGNATURE <u>Blaine Fitzgerald</u>						22c. DATE SIGNED April 26, 1983					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Blaine Fitzgerald M.D.						22e. ADDRESS 8218 Wisconsin Ave. Bethesda, Md. 20814					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE April 26, 1983		23c. NAME OF CEMETERY OR CREMATORY Gate of Heaven		23d. LOCATION CITY OR TOWN COUNTY STATE Silver Spring Maryland					
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey ADDRESS P.A., Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR APR 29 1983		25b. REGISTRAR'S SIGNATURE <u>John S. [Signature]</u>			

BP





river spring Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of entry.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 3 2

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Pota</b>		2a. DATE OF DEATH MONTH DAY YEAR <b>4-17-83</b>	
3. SEX <b>Female</b>		2b. HOUR <b>12 30 AM</b>	
4. RACE <b>White</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>84</b> YRS.	
5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 21, 1898</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Greece</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.	
7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	
10. CITY OR TOWN OF DEATH <b>Bethesda Md.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hosp.</b>		13a. STREET ADDRESS <b>12403 N.H. Avenue, 20904</b>	
13a. STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Silver Spring</b>	
13c. COUNTY <b>Montgomery</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Routzounis</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maria Janetos</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>N/A</b>		16b. SOCIAL SECURITY NO. <b>579-18-7520</b>	
17. INFORMANT ADDRESS <b>George Paul-son- (same as 13e)</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE MYOCARDIAL INSUFFICIENCY</b> <b>4254</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CARDIO MYO PATHY</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <b>ARTERIOSCLEROTIC HEART DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>CHRONIC + ACUTE</b> <b>3 YRS</b> <b>10 YRS</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>CHRONIC PERICARDITIS; GYANALYSIS AGITANS; URINARY TRACT INFECTION</b>			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. LOCATION STREET CITY OR TOWN COUNTY STATE	
21e. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
22a. I certify that (1) (this hospital) attended the deceased from <b>JUNE 19, 1975</b> to <b>APRIL 19, 1983</b> , that (1) (we) lost saw the deceased alive on <b>APRIL 16, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.			
22b. SIGNATURE <b>John B. Nason, MD</b>		22c. DATE SIGNED <b>4-17-83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>JOHN B. NASON, MD.</b>		22e. ADDRESS <b>8000 BASHING DR., SILVER SPRING, MD</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4-20-1983</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Glenwood Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR NAME <b>Hines/Rinaldi Funeral Home</b>		24b. ADDRESS <b>11800 N.H. Ave., Silver Spring, Md.</b>	
25a. DATE REC'D. BY REGISTRAR <b>APR 19 1983</b>		25b. REGISTRAR'S SIGNATURE <b>John B. Nason</b>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETURN TO THE FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE RETURNED TO THE DIVISION OF VITAL RECORDS WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

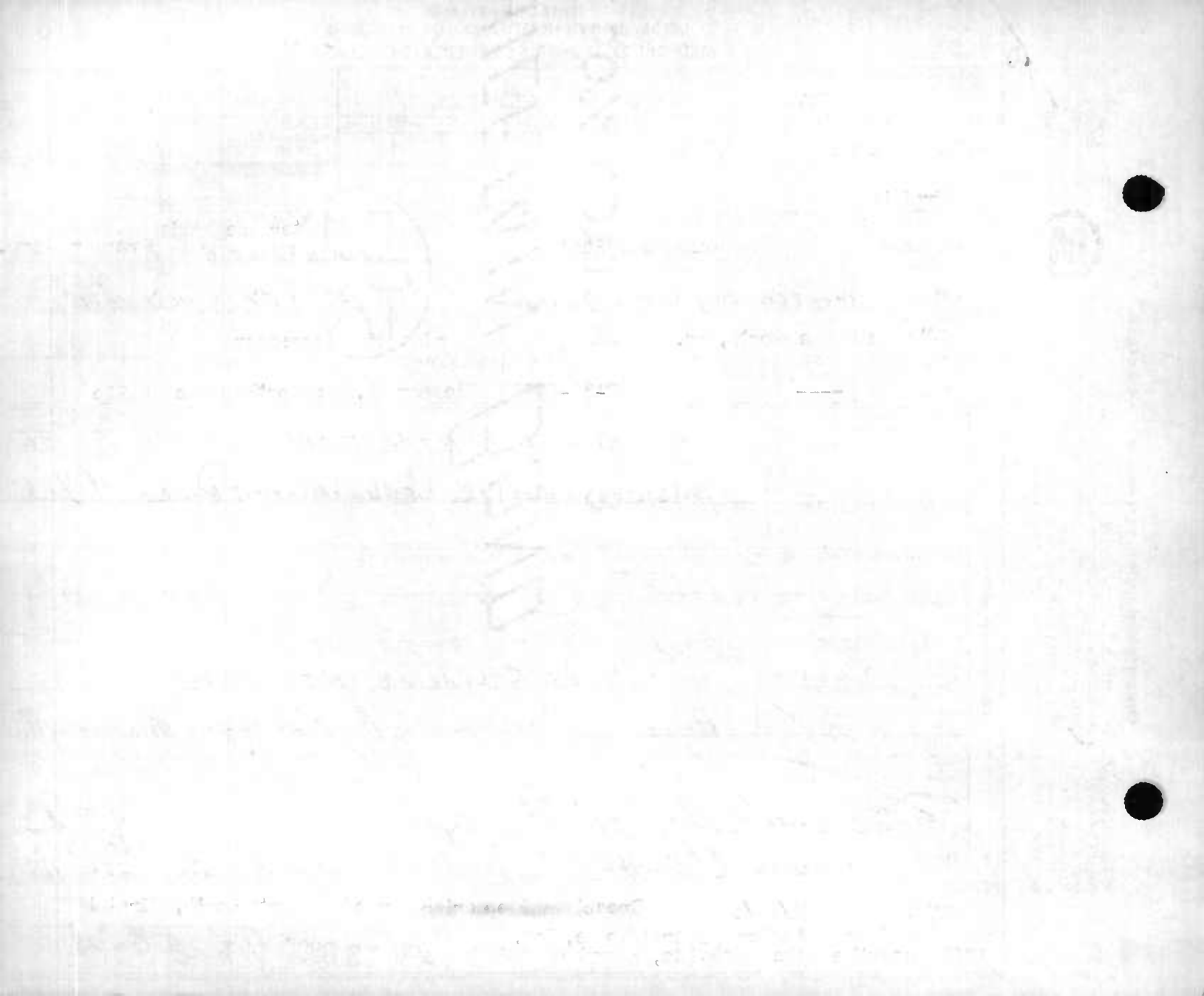
DHMH-17  
(VR A15 ME (1))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>OTTO WELLS PEBWORTH JR</b>			2a. DATE KNOWN OF DEATH MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>4/9/83</b>			2b. HOUR <b>9:08a</b>			
3. SEX <b>male</b>	4. RACE <b>cauc</b>	5. DATE OF BIRTH MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>6/8/30</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>52</b> YRS.	IF UNDER 1 YR. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> <b>4/9/83</b>			2d. HOUR <b>9:08a</b>
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.			
10. CITY OR TOWN OF DEATH <b>Bethesda</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK) <b>Master mechanic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Fremar Corp.</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>MD</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>KENSINGTON</b>					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4008 BRAINARD AVE</b> 20895		
14. FATHER'S NAME <b>Otto Wells Pebworth, Sr.</b>					15. MOTHER'S MAIDEN NAME <b>Nina Jim Culpepper</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>no</b>		16b. SOCIAL SECURITY NO. <b>228-36-6309</b>		17. INFORMANT ADDRESS <b>Eleanor W. Pebworth same as 13e</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>MYOCARDIAN INFARCTION</b> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> 11 YRS (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ACUTE</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____									
19a. DATE OF OPERATION _____			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>4 9 1983</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <b>COLLAPSED AT HOME</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <b>Home</b>		21f. LOCATION STREET <b>4008 BRAINARD AVE</b> CITY OR TOWN <b>Kensington</b> COUNTY <b>Montgomery</b> STATE <b>MD</b>					
22a. I certify that I took charge of the remains described above, held on death resulted from _____ Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from _____ Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Francis C. Mayle</b>		TITLE (SPECIFY) <b>DPT</b>		MEDICAL EXAMINER <b>Proc Wisconsin Ave Bethesda MD</b>		DATE SIGNED <b>4/9/83</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Francis C. Mayle</b>		ADDRESS <b>Proc Wisconsin Ave Bethesda MD</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>4/13/83</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Memorial Gardens</b>			23d. LOCATION CITY OR TOWN <b>Portsmouth, Virginia</b> COUNTY <b>VA</b> STATE <b>VA</b>		
24. FUNERAL DIRECTOR NAME <b>Tyson Wheeler</b> ADDRESS <b>1331 Rockville Pike Rockville, Maryland 20852</b>				25a. DATE REC'D BY REGISTRAR <b>APR 13 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Cahill</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



FOR  
1- STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 3 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2b. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
LILLIA MAE PEET					4 6 83					549 A.M.	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 74 HRS.		
FEMALE	BLACK		MAY 12, 1925		57		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
N.C.	U.S.A.				MONTGOMERY MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
TAKOMA PARK		WASHINGTON ADVENTIST HOSP.				HOUSEWIFE					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.		Montg.		Silver Spring		YES <input type="checkbox"/> NO <input type="checkbox"/>		20904 1185 Good Hope Dr.			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
MCKINLEY BURTON		TENCIE THORPE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
NO		216-64-0739		YVONNE ADAMS (NIECE)		920 Good Hope Dr. Silver Spring Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Respiratory Failure										2 days	
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										4 months.	
(b) Metastatic Lung Cancer											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
BRAIN metastasis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (i) (this hospital) attended the deceased from 5 April 1983 to 6 April 1983, that (i) (we) last saw the deceased alive on 5 April 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (i) (we) (did not) (did not) view the body after death.											
23a. SIGNATURE		DEGREE		23b. DATE SIGNED							
Thomas A. Bensinger		MD		4/6/83							
23c. PHYSICIAN'S NAME (TYPE OR PRINT)		23d. ADDRESS									
THOMAS A. BENNINGER, MD		7676 New Hampshire Ave Langley Park MD									
23e. BURIAL, CREMATION, REMOVAL (SPECIFY)		23f. DATE		23g. NAME OF CEMETERY OR CREMATORY		23h. LOCATION		23i. JURY			
Burial		4-12-83		Parklawn Mem. Pk. Rockville Montg. Md.		20983					
24. FUNERAL DIRECTOR		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
George R. Snowden		2406 N. WASH. ST. Rockville, Md.		APR 11 1983		John J. Carver					

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 0 3 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>FLORENCE PERLMUTTER</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>APRIL 7, 1983</b>			
3 SEX <b>FEMALE</b>				2b. HOUR <b>6:02 A.M.</b>			
4 RACE <b>WHITE</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>JANUARY 23, 1901</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <b>82</b>		7. UNDER 1 YEAR HOURS MIN. <b>00</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
10 CITY OR TOWN OF DEATH <b>SILVER SPRING</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>11700 OLD COLUMBIA PIKE</b>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY COUNTY MD.</b>			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>					
13a. STREET ADDRESS <b>35-51 85th STREET 99999</b>							
14 FATHER'S NAME FIRST MIDDLE LAST <b>(UNASCERTAINABLE) HURWITZ</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>ETTA (UNASCERTAINABLE)</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>058-26-5325A</b>		17 INFORMANT <b>11700 OLD COLUMBIA PIKE ELEANOR OPAL, SILVER SPRING, MARYLAND</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b> <b>1579</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>PANCREATIC CARCINOMA.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>5 MONTHS</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>3:28 P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>11/29</b> 19 <b>82</b> , to <b>4/7</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>3/28</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Alan J. Diamond</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>4/7/83</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ALAN J. DIAMOND</b>				22e. ADDRESS <b>1106 SPRING ST. SILVER SPRING, MD.</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>BURIAL</b>		23b. DATE <b>4/8/1983</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MOUNT HEBRON CEMETERY</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>FLUSHING LONG ISLAND, NEW YORK</b>	
24. FUNERAL HOME <b>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME</b>				25a. DATE REC'D. BY REGISTRAR <b>APR 11 1983</b>			
24. ADDRESS <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>				25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>			



APR 1 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 1 1 0 3 6 REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EVANGELIA PETRIDES				2b. HOUR 11-45 A			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YR Jan. 8, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Greece		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland				13b. COUNTY Montgomery			
13c. CITY OR TOWN Silver Spring				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME (FIRST MIDDLE LAST) (unknown)				15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) (unknown)			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) N/A		16b. SOCIAL SECURITY NO. 577-03-5113 D		17. INFORMANT ADDRESS Georges Petrides-son- (same as 13e)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Severe, Extensive Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Artery Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/4, 19 83, to 4/6, 19 83, that (I) (we) last saw the deceased alive on 4/6, 19 83, and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above. (If we did not view the body after death, so state.)							
22b. SIGNATURE Hermaan B Segal M.D.				DEGREE (Consultant) ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 4/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hermaan B Segal				22e. ADDRESS 5632 Skields Drive Bethesda Md 20816			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 4-8-1983		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Brentwood Pr. Georges Md.	
24. FUNERAL DIRECTOR Hines/Rinaldi Funeral Home Silver Spring, Md.				25a. DATE REC'D. BY REGISTRAR APR 11 1983			
25b. REGISTRAR'S SIGNATURE John J. Lohr							



Dr. J. Rogers  
Cleared by med. Examiner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 83 11037			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rose J. Pietrantoni				2a. DATE OF DEATH MONTH DAY YEAR April 9, 1983		2b. HOUR 4:00p.m.	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 09 01 1892		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Puerto Rico		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.	
10. CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker Ret.		12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Antonio Pietrantoni		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Olimpia Enanuelli		16. STREET ADDRESS 2509 Hayden Drive 20902			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT ADDRESS 2509 Hayden Drive Jorge Felices-Pietrantoni, Son S. S. Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIAC ARREST DUE TO, OR AS A CONSEQUENCE OF (b) HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) SENILITY				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 45 min. YEARS			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 9 Apr 1983, to 9 Apr 1983, that (I) (we) lost saw the deceased alive on 9 Apr 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and not) view the body after death.							
22b. SIGNATURE Ira N. Tublin				22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22d. DATE SIGNED 9 Apr 1983	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) IRA N. TUBLIN				22f. ADDRESS 8830 Cameron ST Silver Spring Md			
23a. BURIAL OR CREMATION, REMAINS (SPECIFY) Cremation		23b. DATE Apr. 11, 1983		23c. NAME OF CHURCH OR CREMATORY Cedar Hill Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P. G. Cty., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS W. W. CHAMBERS CO. 8655 Ga., Ave., SS, Md. 20916				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE APR 17 1983			

1911. 1912. 1913. 1914. 1915. 1916. 1917. 1918. 1919. 1920. 1921. 1922. 1923. 1924. 1925. 1926. 1927. 1928. 1929. 1930. 1931. 1932. 1933. 1934. 1935. 1936. 1937. 1938. 1939. 1940. 1941. 1942. 1943. 1944. 1945. 1946. 1947. 1948. 1949. 1950. 1951. 1952. 1953. 1954. 1955. 1956. 1957. 1958. 1959. 1960. 1961. 1962. 1963. 1964. 1965. 1966. 1967. 1968. 1969. 1970. 1971. 1972. 1973. 1974. 1975. 1976. 1977. 1978. 1979. 1980. 1981. 1982. 1983. 1984. 1985. 1986. 1987. 1988. 1989. 1990. 1991. 1992. 1993. 1994. 1995. 1996. 1997. 1998. 1999. 2000. 2001. 2002. 2003. 2004. 2005. 2006. 2007. 2008. 2009. 2010. 2011. 2012. 2013. 2014. 2015. 2016. 2017. 2018. 2019. 2020. 2021. 2022. 2023. 2024. 2025. 2026. 2027. 2028. 2029. 2030. 2031. 2032. 2033. 2034. 2035. 2036. 2037. 2038. 2039. 2040. 2041. 2042. 2043. 2044. 2045. 2046. 2047. 2048. 2049. 2050. 2051. 2052. 2053. 2054. 2055. 2056. 2057. 2058. 2059. 2060. 2061. 2062. 2063. 2064. 2065. 2066. 2067. 2068. 2069. 2070. 2071. 2072. 2073. 2074. 2075. 2076. 2077. 2078. 2079. 2080. 2081. 2082. 2083. 2084. 2085. 2086. 2087. 2088. 2089. 2090. 2091. 2092. 2093. 2094. 2095. 2096. 2097. 2098. 2099. 2100. 2101. 2102. 2103. 2104. 2105. 2106. 2107. 2108. 2109. 2110. 2111. 2112. 2113. 2114. 2115. 2116. 2117. 2118. 2119. 2120. 2121. 2122. 2123. 2124. 2125. 2126. 2127. 2128. 2129. 2130. 2131. 2132. 2133. 2134. 2135. 2136. 2137. 2138. 2139. 2140. 2141. 2142. 2143. 2144. 2145. 2146. 2147. 2148. 2149. 2150. 2151. 2152. 2153. 2154. 2155. 2156. 2157. 2158. 2159. 2160. 2161. 2162. 2163. 2164. 2165. 2166. 2167. 2168. 2169. 2170. 2171. 2172. 2173. 2174. 2175. 2176. 2177. 2178. 2179. 2180. 2181. 2182. 2183. 2184. 2185. 2186. 2187. 2188. 2189. 2190. 2191. 2192. 2193. 2194. 2195. 2196. 2197. 2198. 2199. 2200. 2201. 2202. 2203. 2204. 2205. 2206. 2207. 2208. 2209. 2210. 2211. 2212. 2213. 2214. 2215. 2216. 2217. 2218. 2219. 2220. 2221. 2222. 2223. 2224. 2225. 2226. 2227. 2228. 2229. 2230. 2231. 2232. 2233. 2234. 2235. 2236. 2237. 2238. 2239. 2240. 2241. 2242. 2243. 2244. 2245. 2246. 2247. 2248. 2249. 2250. 2251. 2252. 2253. 2254. 2255. 2256. 2257. 2258. 2259. 2260. 2261. 2262. 2263. 2264. 2265. 2266. 2267. 2268. 2269. 2270. 2271. 2272. 2273. 2274. 2275. 2276. 2277. 2278. 2279. 2280. 2281. 2282. 2283. 2284. 2285. 2286. 2287. 2288. 2289. 2290. 2291. 2292. 2293. 2294. 2295. 2296. 2297. 2298. 2299. 2300. 2301. 2302. 2303. 2304. 2305. 2306. 2307. 2308. 2309. 2310. 2311. 2312. 2313. 2314. 2315. 2316. 2317. 2318. 2319. 2320. 2321. 2322. 2323. 2324. 2325. 2326. 2327. 2328. 2329. 2330. 2331. 2332. 2333. 2334. 2335. 2336. 2337. 2338. 2339. 2340. 2341. 2342. 2343. 2344. 2345. 2346. 2347. 2348. 2349. 2350. 2351. 2352. 2353. 2354. 2355. 2356. 2357. 2358. 2359. 2360. 2361. 2362. 2363. 2364. 2365. 2366. 2367. 2368. 2369. 2370. 2371. 2372. 2373. 2374. 2375. 2376. 2377. 2378. 2379. 2380. 2381. 2382. 2383. 2384. 2385. 2386. 2387. 2388. 2389. 2390. 2391. 2392. 2393. 2394. 2395. 2396. 2397. 2398. 2399. 2400. 2401. 2402. 2403. 2404. 2405. 2406. 2407. 2408. 2409. 2410. 2411. 2412. 2413. 2414. 2415. 2416. 2417. 2418. 2419. 2420. 2421. 2422. 2423. 2424. 2425. 2426. 2427. 2428. 2429. 2430. 2431. 2432. 2433. 2434. 2435. 2436. 2437. 2438. 2439. 2440. 2441. 2442. 2443. 2444. 2445. 2446. 2447. 2448. 2449. 2450. 2451. 2452. 2453. 2454. 2455. 2456. 2457. 2458. 2459. 2460. 2461. 2462. 2463. 2464. 2465. 2466. 2467. 2468. 2469. 2470. 2471. 2472. 2473. 2474. 2475. 2476. 2477. 2478. 2479. 2480. 2481. 2482. 2483. 2484. 2485. 2486. 2487. 2488. 2489. 2490. 2491. 2492. 2493. 2494. 2495. 2496. 2497. 2498. 2499. 2500. 2501. 2502. 2503. 2504. 2505. 2506. 2507. 2508. 2509. 2510. 2511. 2512. 2513. 2514. 2515. 2516. 2517. 2518. 2519. 2520. 2521. 2522. 2523. 2524. 2525. 2526. 2527. 2528. 2529. 2530. 2531. 2532. 2533. 2534. 2535. 2536. 2537. 2538. 2539. 2540. 2541. 2542. 2543. 2544. 2545. 2546. 2547. 2548. 2549. 2550. 2551. 2552. 2553. 2554. 2555. 2556. 2557. 2558. 2559. 2560. 2561. 2562. 2563. 2564. 2565. 2566. 2567. 2568. 2569. 2570. 2571. 2572. 2573. 2574. 2575. 2576. 2577. 2578. 2579. 2580. 2581. 2582. 2583. 2584. 2585. 2586. 2587. 2588. 2589. 2590. 2591. 2592. 25



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

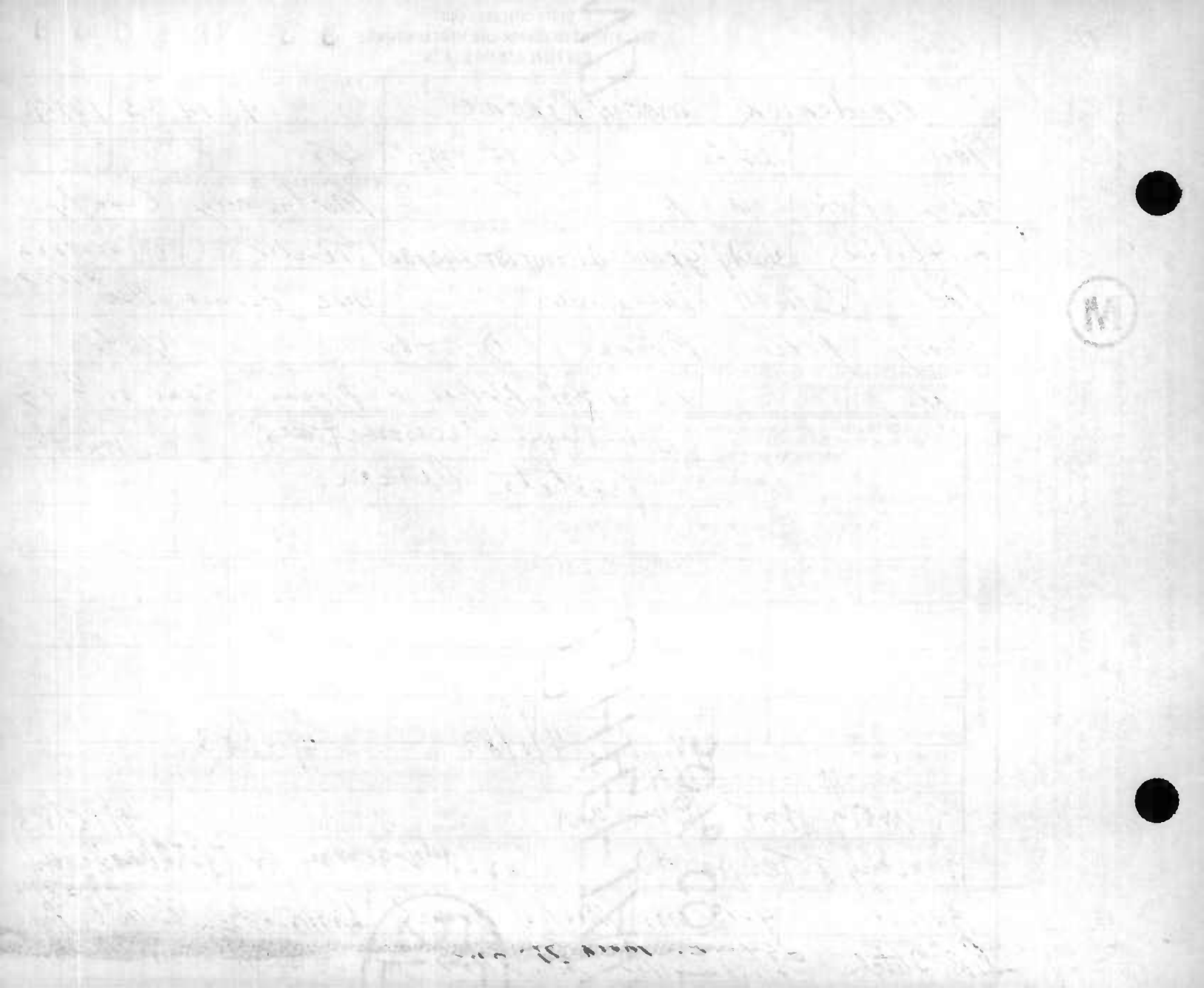
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the instructions by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 83 11038   |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><i>Brederick Martin Piroe</i>  |  |   |  | 2b. HOUR<br><i>4 14 83 1815PM</i>   |  |   |  |
| 3. SEX<br><i>Male</i>  |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><i>4-13-1955</i>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS<br><i>48</i>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Takoma Park</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery County MD.</i>  |  |
| 10. CITY OR TOWN OF DEATH<br><i>Caitersburg</i>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Shady Grove Adventist Hospital</i>   |  |   |  | 12a. USUAL OCCUPATION (TYPE OR TASK FOR MOST OF WORKING LIFE)<br><i>Teacher</i>   |  |
| 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Education</i>  |  | 13a. STREET ADDRESS<br><i>442 Barnes Ave.</i>   |  | 13b. CITY OR TOWN<br><i>Westminster</i>   |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 13d. COUNTY<br><i>Carroll</i>  |  | 13e. STATE<br><i>Md.</i>  |  | 13f. CITY OR TOWN<br><i>Westminster</i>   |  | 13g. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 4. FATHER'S NAME FIRST MIDDLE LAST<br><i>Harry Peter Piroe</i>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><i>Dorothy Yates</i>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><i>No</i>  |  | 16b. SOCIAL SECURITY NO.<br><i>476-34-3635</i>  |  |
| 17. INFORMANT ADDRESS<br><i>Archie F. Piroe same as #13</i>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Prostate Cancer</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1950</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>6 months</i>   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><i>P.M. 4/14/83 4/1/83 19</i>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>                   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE<br><i>4/14/83 4/1/83 19 4/14/83</i>  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased on <i>4/14/83</i> and that (my) (our) opinion death occurred on the date and hour and from the causes stated |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br><i>Timothy J. Tehan M.D.</i>   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>    |  | 22c. DATE SIGNED<br><i>4/15/83</i>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Timothy J. Tehan M.D.</i>  |  | 22e. ADDRESS<br><i>8218 Wisconsin Ave. Bethesda Md.</i>   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i>  |  | 23b. DATE<br><i>4-18-1983</i>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br><i>Meadow Brook</i>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><i>Westminster Carroll Md.</i>   |  | 24. FUNERAL DIRECTOR (NAME)<br><i>Ed Hatch</i>  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 19 1983</i>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John J. Smith</i>   |  | 25c. REGISTRAR'S NAME (TYPE OR PRINT)<br><i>John J. Smith</i>   |  | 25d. REGISTRAR'S ADDRESS<br><i>254 E. Main St. Westminster Md. 21157</i>  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |  |  |   | 8 3 1 1 0 3 9   |  |
|--|--|--|--|---|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |   |  |   |  |  |   | REG. NO.  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harold Percival Plumb</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 28, 1983</b>  |  |  | 2b. HOUR<br><b>2:40p M</b>  |   |  |
| 3. SEX<br><b>Male</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>January 5, 1924</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>59</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |   | IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>India</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>Great Britian</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                                    |  |  |   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NIH, The Clinical Center</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>mechanic</b>                     |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Aircraft Mfg</b>              |   |  |
| 13a. STATE<br><b>Washington</b>  |  | 13b. COUNTY<br><b>NO. COUNTY</b>   |  | 13c. CITY OR TOWN<br><b>Seattle</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                    |  | 13e. STREET ADDRESS<br><b>4761 21st Ave., SW 98106</b> 9999  |   |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Plumb</b>   |  |  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Myrtle Raphael</b>                                  |  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>  |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>553-90-8801</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Mrs. Theresa Plumb (wife)</b>  |  |  |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIAC ARRYTHMIA</b><br><b>4140</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>SECONDARY TO CORONARY ARTERY ATHEROSCLORATIC DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</b>  |  |  |  |   |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 HOUR</b><br><b>YEARS</b>   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br><b>3 Vessel Coronary Artery Disease - Unable to wean from cardiopulmonary bypass</b>  |  |  |  |   |  |   |  |  |   |   |  |
| 19a. DATE OF OPERATION<br><b>April 28, 1983</b>  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>CAD</b>  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)                          |  |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |   |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 16, 1983</b> , to <b>April 28, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 28, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) not view the body after death. |  |  |  |   |  |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Robert Artwoul</b> MD   |  |  |  |   |  | DEGREE<br><b>MD</b>   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |   | 22c. DATE SIGNED<br><b>4/29/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert Artwoul</b>   |  |  |  |   |  | 22e. ADDRESS<br><b>CC, National Institutes of Health, 9000 Rockville Pike, Bethesda, Maryland 20205</b> |  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |  |  |  | 23b. DATE<br><b>4-30-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b> |   |  |
| 24. FUNERAL DIRECTOR<br><b>Marshall's Funeral Home</b><br><b>4217 9th Street NW: Washington, D.C.</b>  |  |  |  |   |  | 25. DATE REC'D. BY REGISTRAR<br><b>MAY 5 1983</b>   |  |  |   |   |  |
|  |  |  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conrad</b>   |  |  |   |   |  |



100% COTTON



MADE IN U.S.A. 100% COTTON

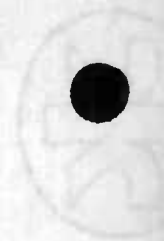
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | 8 3 1 1 0 4 0  |  |   |  |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Anna E Pollard</b>   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>4-20-83</b>  |  | 2b. HOUR <b>4:28</b> M  |  |
| 3. SEX <b>Female</b>   |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>12-03-97</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS   |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Mass</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Chief clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Telephone Co</b>   |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Mont.</b>  |  | 13c. CITY OR TOWN <b>Wheaton</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Henry Goddard</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Clarke</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  |   |  |
| 16b. SOCIAL SECURITY NO. <b>028 28 8960</b>  |  | 17. INFORMANT ADDRESS <b>Charles E. Pollard (son) #13</b>   |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest</b><br><b>4100</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____ |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b> P.M.   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 19 1983</b> to <b>April 20 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE <b>John M. Rendino</b> DEGREE   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED <b>4/20/83</b>   |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John M. Rendino, M.D.</b>   |  |   |  | 23b. ADDRESS <b>11620 Kemp M. H. Rd SS, MD.</b>  |  |   |  |
| 23c. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>   |  | 23d. DATE <b>Apr. 22, 1983</b>  |  | 23e. NAME OF CEMETERY OR CREMATORY <b>Lee Crematory</b>  |  | 23f. LOCATION CITY OR TOWN COUNTY STATE <b>Wash. D.C.</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>W.W. Taltavull</b>  |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 26 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>Joan J. Connel</b>  |  |
| 4748 Wisc. Ave. N.W. Wash. D.C.  |  |   |  |  |  |   |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1. FOR STATE REGISTRAR   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 3 1 1 0 4 1  |  |
|--|--|---|--|--|--|
| DECEASED NAME (PRINT)  |  | FIRST MIDDLE LAST   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
| DOROTHY Hooton Porter  |  |   |  | 4/19/83  |  |
| 3. SEX<br>Female   |  | 4. RACE<br>white  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>24 May 1898   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br>84  |  | 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Charleston, W. Va.  |  | 8. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery   |  | 10. CITY OR TOWN OF DEATH<br>Olney  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BROOKE GROVE Nsg. Home |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>None   |  | 13a. STREET ADDRESS<br>810 Ashton Road   |  |
| 13b. COUNTY<br>Md.   |  | 13c. CITY OR TOWN<br>Sandy Spring   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Ferdinand Velance Hooton  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Louise Antoinette Rogers  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No  |  |
| 16b. SOCIAL SECURITY NO.<br>None   |  | 16c. SOCIAL SECURITY NO.<br>578-20-6782 A   |  | 17. INFORMANT<br>Sandy Spring, Md. 20860<br>Robert H. Porter-son 810 Ashton Rd.  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for each, and PART 1. DEATH WAS CAUSED BY:<br>2639 IMMEDIATE CAUSE (a) <u>Diagnosed by failure</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>depression</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <u>depression</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>depression</u><br>(c) <u>depression</u> |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)  |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  | 22a. I certify that (I) (this hospital) attended the deceased from 19 76 to 4/19/83, that (I) (we) lost saw the deceased alive on 4/15/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE <u>[Signature]</u> DEGREE <u>MD</u>   |  |
| 22c. DATE SIGNED<br>4/20/83  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>C. H. L. [Signature]   |  | 22e. ADDRESS<br>18111 P. Phillips St., Olney Md 20832  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Cremation   |  | 23b. DATE<br>4-20-1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee's Crematory  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Washington, D.C.  |  | 24. FUNERAL DIRECTOR<br>Lee Funeral Home 300-4th St. N.E. Wash. D.C. 20002  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 25 1983   |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 3 1 1 0 4 2  |  |   |  |
|--|--|--|--|---|--|--|--|--|--|---|--|
| CERTIFICATE OF DEATH   |  |  |  | REG. NO.  |  |  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Concetta Porto</i>  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>Apr 23 1983</i>  |  |  |  | 2b. HOUR<br><i>5 19</i> M  |  |   |  |
| 3. SEX<br><i>female</i>  |  | 4. RACE<br><i>Cauc</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>July 10, 1923</i>   |  | 6. AGE<br>(IN YEARS LAST BIRTHDAY) <i>89</i> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY) <i>Italy</i>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. <input checked="" type="checkbox"/> MARRIED <input checked="" type="checkbox"/> SINGLE <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD.                        |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><i>Kensington</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Kensington Gerd Nsg. CTR.</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>    |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>own home</i>   |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <i>MARYLAND</i> 13b. COUNTY <i>Prince Georges</i> 13c. CITY OR TOWN <i>Hyattsville</i>  |  |  |  | 15. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13. STREET ADDRESS<br><i>6902 22nd Ave</i>   |  | 20783  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST <i>Frank Micelli</i>  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST <i>Grazia D'Angelo</i>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>N/A</i>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES) <i>N/A</i>   |  | 17. INFORMANT<br>ADDRESS <i>Carmela Lombardo-daughter-(same as 13e)</i>   |  |  |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><i>1749</i> IMMEDIATE CAUSE (a) <i>metastatic carcinoma of breast</i><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |  |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1977</i> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |  |  |   |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. <i>19</i>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>12/11</i> , 19 <i>82</i> , to <i>4/23</i> , 19 <i>83</i> , that (1) (we) last saw the deceased alive on <i>4/23</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.            |  |  |  |   |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><i>Martin C Shargel</i>  |  |  |  | DEGREE<br><i>M.D.</i>   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>4/23/83</i>                          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>MARTIN C. SHARGEL, M.D.</i>  |  |  |  | 22e. ADDRESS<br><i>3720 FARRAGUT AVE.<br/>KENSINGTON, MARYLAND-20895</i>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <i>Burial</i>   |  | 23b. DATE<br><i>4-27-1983</i>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Fort Lincoln</i>   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Brentwood Pr. Georges Md.</i>       |  |  |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <i>Hines/Rinaldi Funeral Home</i> ADDRESS <i>11800 N.H. Ave., Silver Spring, Md.</i>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 26 1983</i>   |  | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Linnell</i>                                 |  |  |  |   |  |



Historical Commission Report



20% COLLECTION



Walter C. Shaffer, M.D.  
Walter C. Shaffer, M.D.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                         |  |  |  |  |  |  |  | REG. NO. 83 11043  |  |
|--|--|-------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARY AGNES POTTER</b>   |  |                         |  |  |  | 2a. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>04 24 19 83</b>  |  | 2b. HOUR<br><b>2:00 PM</b>   |  |  |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Cauca</b> |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>09 24 03 79</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN.<br><b>79 YRS.</b>  |  | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR<br><b>4 24 19 83</b>   |  | 2d. HOUR<br><b>2:50 PM</b>                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Mass</b>   |  |                         |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                                       |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  |  |                         |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Bank Teller</b>                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Banking</b>              |  |
| 13a. STATE<br><b>Mass.</b>   |  |                         |  | 13b. COUNTY<br><b>Berkshire</b>  |  | 13c. CITY OR TOWN<br><b>Adams</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  | 13e. STREET ADDRESS<br><b>9 Orchard Street</b>                   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Edward D. Potter</b>   |  |                         |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Agnes Orr</b>   |  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b> |  |  |  |
| 16a. SOCIAL SECURITY NO.<br><b>020-03-5610</b>   |  |                         |  | 17. INFORMANT<br><b>Nephew</b>   |  |  |  | ADDRESS<br><b>912 Cottage St. Marshall O. Potter, Jr. Vienna, Va.</b>                                      |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4149 IMMEDIATE CAUSE (a) CORONARY ARTERY DISEASE</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                         |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.  |  |                         |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |                         |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                        |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                         |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)                              |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  |                         |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                         |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE<br><b>John Given</b>  |  |                         |  | TITLE (SPECIFY)<br><b>Deputy</b>   |  |  |  | DATE SIGNED<br><b>4/24/83</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)<br><b>John Given</b>   |  |                         |  | M.D.<br><b>M.D.</b>  |  |  |  | ADDRESS<br><b>1516 Tanyard Hill Rd Gaith, Md</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  |                         |  | 23b. DATE<br><b>April 27, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Bellevue Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Adams, Massachusetts</b>                                     |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br><b>ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND</b>   |  |                         |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 26 1983</b>  |  | REGISTRAR'S SIGNATURE<br><b>John J. Given</b>  |  |  |  |

BP



OFFICE



1/24/83

1st copy of letter to Mr. [illegible]

Mr. [illegible]

1/24/83

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  | 8 3 1 1 0 4 4   |  |
|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR <b>ERNESTINE LAWTON PROVANCE</b>   |  |   |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>ER nestine L. PROVANCE</b>  |  |   |  | 20. DATE OF DEATH MONTH DAY YEAR 2b HOUR<br><b>April 21, 1983 1 19 P.M.</b>   |  |
| 3. SEX <b>FEMALE</b>  |  | 4. RACE <b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>May 7, 1904</b>   |  |
| 6. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Martinsburg, W.Va.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10. CITY OR TOWN OF DEATH <b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Lutheran Home for the Aged</b>  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.  |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Textile Mill Worker</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Mill</b>  |  | 13. STREET ADDRESS<br><b>222 S. Maple Street</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>Charges E. Lawton</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Cora Poisal</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b><br>16b. SOCIAL SECURITY NO. <b>234-01-6449</b>                                  |  |
| 17. INFORMANT ADDRESS<br><b>Rev. Richard Reichard 9701 Veirs Dr. Rockville Md.</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Pneumonia</b><br>4860<br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Diabetes Mellitus</b>  |  |   |  |   |  |
| 19a. DATE OF OPERATION<br><b>—</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 3, 19 83</b> , to <b>April 21, 19 83</b> , that (I) (we) last saw the deceased alive on <b>April 20, 19 83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |   |  |   |  |
| 22b. SIGNATURE <b>Harold F. McCann</b> DEGREE <b>M.D.</b>   |  |   |  | 22c. DATE SIGNED <b>4-21-83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD F. MCCANN</b>   |  |   |  | 22e. ADDRESS <b>3355-16th St. N.W. WASH. DC. 20010.</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>April 25, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Rosedale Cemetery</b>   |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Martinsburg, West Virginia</b>  |  | 24. FUNERAL DIRECTOR NAME ADDRESS<br><b>The Hysong Company 1300 N St. N.W. Washington, D.C.</b>   |  |   |  |
| 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE <b>John E. Connel</b>  |  |   |  |



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CABLE  
FURNAM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the county after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8311045   |  |   |   |
|---|--|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH   |  |   |   |
| George A Pugh   |  |  |  | 4/28/83   |  |   |   |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE  |   |
| Male  |  | Caucasian  |  | 3 08 07   |  | 76 YRS.   |   |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |   |
| Maryland  |  | United States  |  |   |  | Montgomery MD.  |   |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN A HOSPITAL, FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |   |
| Bethesda  |  | Suburban Hospital  |  | Carpenter   |  | Building  |   |
| 13a. STATE  |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?  |  | 13d. STREET ADDRESS   |   |
| DC  |  | Washington   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | (20015) 4347 Harrison Street, N.W.                                  |   |
| 14. FATHER'S NAME   |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |   |   |
| George Alexander Pugh   |  |  |  | Mabel Irene Parker  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)  |  |  |  | 16b. SOCIAL SECURITY NO.  |  |   |   |
| Yes WW II   |  |  |  | 579-01-8218   |  |   |   |
| 17. INFORMANT   |  |  |  | ADDRESS   |  |   |   |
| Donald L. Pugh  |  |  |  | 13409 Crispin Way Rockville, MD 20853   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>2089 IMMEDIATE CAUSE (a) Respiratory Failure<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Left lower lobe, lung consolidation due to pneumonia<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) leukemia |  |  |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>1 week<br>4 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |   |  |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |   |
|   |  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)  |  |   |   |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |   |
|   |  |  |  |   |  |   |   |
| 22a. I certify that (this hospital) attended the deceased from May 19 54, to 28 Apr 19 83, that (I) (we) lost above, (b) (we) (did) (did not) view the body after death.  |  |  |  |   |  |   |   |
| 22b. SIGNATURE  |  |  |  | DEGREE  |  | 22c. DATE SIGNED  |   |
| Eugene P. Libbre MD   |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 4/29/83   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS  |  |   |   |
| EUGENE P. LIBBRE MD   |  |  |  | 10400 CONNECTICUT AVE<br>KENSINGTON MD 20885  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |   |
| Burial  |  | 3, 1983  |  | Parklawn Mem. Park  |  | Rockville, Maryland   |   |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE  |   |
| Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814   |  |  |  | MAY 2 1983  |  | John J. Conner  |   |





WHEATON  
COLLEGE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
|--|---------|------------------|--|---|------------------|--|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |         |                  | FIRST MIDDLE LAST  |   |                  | 2d. DATE KNOWN OF DEATH  |  |   | MONTH DAY YEAR                             |   |  | 2b. HOUR                                   |  |  |  |
| Matthew  |         |                  | C.   |   |                  | Pulupa   |  |   | 4-19                                       |   |  | 19 83                                      |  |  |  |
| 3. SEX   | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS)  | IF UNDER 1 YR.  | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD   |  |   | MONTH DAY YEAR                             |   |  | 2d. HOUR                                   |  |  |  |
| Male   | Cauc.   | Dec. 23, 1982    | 3 YRS.   | 3   | 26               | 4-19   |  |   | 19 83                                      |   |  | 7:19 P.M.                                  |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |         |                  | 7b. CITIZEN OF WHAT COUNTRY?   |   |                  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH       |   |  |  |  |  |  |
| Washington, D.C.   |         |                  | U.S.A.   |   |                  |  |  |   | Montgomery County MD.                      |   |  |  |  |  |  |
| 11. CITY OR TOWN OF DEATH  |         |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |                  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |   | 12b. KIND OF BUSINESS OR INDUSTRY          |   |  |  |  |  |  |
| Rockville  |         |                  | Shady Grove Hospital   |   |                  | None   |  |   | None                                       |   |  |  |  |  |  |
| 14. FATHER'S NAME  |         |                  | 15. MOTHER'S MAIDEN NAME   |   |                  | 13d. INSIDE CITY LIMITS?   |  |   | 13. STREET ADDRESS                         |   |  |  |  |  |  |
| Rene G. Pulupa   |         |                  | Ellen Ryan   |   |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |   | 17701 Topfeild Dr. 20877                   |   |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)  |         |                  | 16b. SOCIAL SECURITY NO.   |   |                  | 17. INFORMANT  |  |   | ADDRESS                                    |   |  |  |  |  |  |
| No   |         |                  | None   |   |                  | Rene G. Pulupa   |  |   | 17701 Topfeild Dr. Gaithersburg, MD. 20877 |   |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
| PART I DEATH WAS CAUSED BY:  |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
| 7980 IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome  |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF   |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:  |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
| (b) DUE TO, OR AS A CONSEQUENCE OF   |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
| (c)  |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).  |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |         |                  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?           |                  |  |  |   |  | 20. AUTOPSY?  |  |  |  |  |  |
|  |         |                  |  |   |                  |  |  |   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |         |                  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |                  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |         |                  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) |                  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                             |  |   |  |  |  |  |  |
|  |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |
| ACTUAL SIGNATURE   |         |                  |  | TITLE (SPECIFY)   |                  |  |  | DATE SIGNED   |  |   |  |  |  |  |  |
| Dennis F. Smyth M.D.   |         |                  |  | M.D. Assistant MEDICAL EXAMINER                             |                  |  |  | 4-20-83   |  |   |  |  |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)   |         |                  |  | ADDRESS   |                  |  |  |   |  |   |  |  |  |  |  |
| Dennis F. Smyth, M.D.  |         |                  |  | 111 Penn Street, Baltimore, Md.                             |                  |  |  |   |  |   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |         |                  |  | 23b. DATE   |                  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE |  |  |  |
| Cremation  |         |                  |  | 4-21-1983   |                  |  |  | Lee's Crematory   |  |   |  | Washington, D.C.                           |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME   |         |                  |  | 25a. DATE REC'D. BY REGISTRAR                               |                  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |  |  |  |  |
| Gartner-Sandison Funeral Home  |         |                  |  | APR 26 1983   |                  |  |  | J. C. J. Carroll  |  |   |  |  |  |  |  |
| 316 E. Diamond Ave. Gaithersburg, MD. 20760  |         |                  |  |   |                  |  |  |   |  |   |  |  |  |  |  |

RECEIVED  
FEB 10 1964

NAME: JAMES E. JONES  
ADDRESS: 1000 N. 10th St.,  
Ocala, Florida 32668  
CITY: Ocala  
STATE: FLA.  
ZIP: 32668  
DATE: 1/15/64  
TIME: 10:00 AM  
FROM: JAMES E. JONES  
TO: JAMES E. JONES  
SUBJECT: JAMES E. JONES  
RE: JAMES E. JONES

DAVID  
JONES

STATION  
CITY - JAMES E. JONES  
STATE - FLA.  
ZIP - 32668  
DATE - 1/15/64  
TIME - 10:00 AM  
FROM - JAMES E. JONES  
TO - JAMES E. JONES  
SUBJECT - JAMES E. JONES  
RE - JAMES E. JONES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

DHMH - 16 50M 4/82  
(VRA 15, 4)

FOR  
1. STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

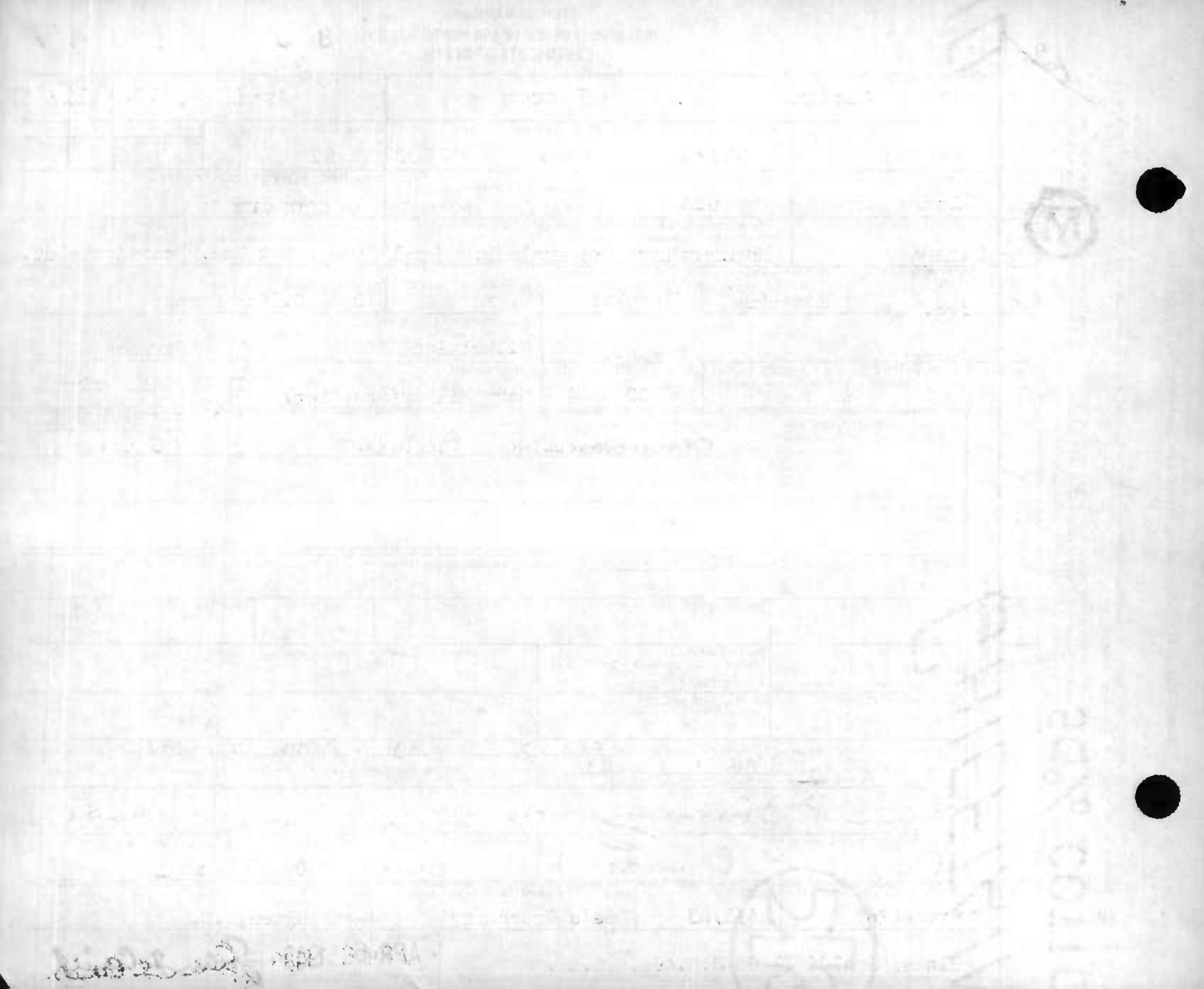
8 3

1 1 0 4 7

REG. NO.

|  |   |  |  |   |   |  |
|--|---|--|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Claire E. Putrow</b>  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 4, 1983</b>                                |   | 2b. HOUR<br><b>12:25P</b>   |  |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Dec. 4 1900</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>82</b>  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Wisconsin</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Hutner Mat Inc.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>President-Ret.</b>            |  |
| 13a. STATE<br><b>Wisc.</b>   |   | 13b. COUNTY<br><b>Milwaukee</b>  | 13c. CITY OR TOWN<br><b>Milwaukee</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>August Loese</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Wilhelmine Steege</b>  |  | 13e. STREET ADDRESS<br><b>3041 S. 56th Street</b>   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>None</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>388 32 5904</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>Mary Miller (Daughter) 17016 Woodale Drive S.S.Md. 20904</b>     |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b><br><b>4360</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 WEEKS</b>        |  |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |   |  |  |   |   |  |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |   |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>FEB 12, 1983</b> to <b>APRIL 4, 1983</b> , that (I) (we) last saw the deceased alive on <b>APRIL 4, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.                                   |   |  |  |   |   |  |
| 22b. SIGNATURE<br><b>Eugene P. Flannery</b>  |   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>APRIL 5, 1983</b>  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>EUGENE P. FLANNERY</b>   |   | 22e. ADDRESS<br><b>18111 PRINCE PHILIP DR. OLNEY, MD. 20833</b>  |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   |   | 23b. DATE<br><b>4/5/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>                               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi 11800 N.H.Ave.S.S.Md.</b>   |   | ADDRESS  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 6 1983</b>  |   |  |
|  |   |  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>   |   |  |

999999



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 17 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP \_\_\_\_\_

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |                  |   |   |   |   |  |   |  |
|---|------------------|---|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Beatrice Vera Quigg  |                  |   | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>3 11 19 83  |   |   | 7b. HOUR<br>M<br>10:04 a.m.  |   |  |
| 3. SEX<br>Female  | 4. RACE<br>White | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 23 1935   | 6. AGE (IN YEARS)<br>(LAST BIRTHDAY)<br>47 YRS.   | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   | 2c. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 11 19 83  | 7d. HOUR<br>M<br>10:04 a.m.  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>England  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD.                                       |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Cafeteria Worker               |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Mont. Co. Sch. |  |
| 13a. STATE<br>Maryland  |                  |   | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Rockville  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Frederick Baker   |                  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Vera Victoria Veressy                                      |   |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No   |                  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>None   |   |   | 17. INFORMANT<br>Rockville, Md. 20851<br>Bettie S. Matson =1800 Crawford Drive                       |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 9654 Gunshot wounds of Chest (Unspecified)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.   |                  |   |   |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |                  |   |   |   |   |  |   |  |
| 19a. DATE OF OPERATION  |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                  |   |  |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>9:10xx 3 11 1983   |   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>subject was shot    |   |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>Home   |   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>1940 Lewis Ave., Rockville, Montgomery Co., Md. |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                  |   |   |   |   |  |   |  |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth</i>  |                  |   | TITLE (SPECIFY)<br>M.D. Assistant   |   |   | DATE SIGNED<br>3-12-83   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.   |                  |   | ADDRESS<br>111 Penn Street  |   |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |                  |   | 23b. DATE<br>3/16/83  |   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Fort Lincoln   |   |  |
| 23d. LOCATION<br>(CITY OR TOWN) COUNTY STATE<br>Brentwood Prince George Md.   |                  |   | 24. FUNERAL DIRECTOR<br>NAME<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Maryland |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAR 17 1983   |   |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>P. J. Carver</i>   |                  |   |   |   |   |  |   |  |

TO : SAC, NEW YORK

FROM : SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

FOR: [Illegible]

THROUGH: [Illegible]

ATTENTION: [Illegible]

NOTES: [Illegible]

REFERENCE: [Illegible]

ENCLOSURE: [Illegible]

ADMINISTRATIVE: [Illegible]

OTHER: [Illegible]

REMARKS: [Illegible]

SIGNATURE: [Illegible]

DATE: [Illegible]

BY: [Illegible]

RECEIVED BY THE DIRECTOR  
U.S. DEPARTMENT OF JUSTICE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please do not retain by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 4 9

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH  |  | MONTH DAY YEAR   |  | 2b. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  |
| MARGARET ELIZABETH RABIDA  |  | FEMALE   |  | WHITE  |  | Jan. 10, 1896   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Colorado   |  | United States  |  |  |  | 86 YRS.   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Rockville  |  | Collingswood Nursing Home  |  | Clerk  |  | U.S. Gov't  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  |
| Maryland   |  | Montgomery   |  | Rockville  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS  |  |   |  |
| Martin M. Krasovich  |  | Mary Prus  |  | 6621 Sulky Lane 20852  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  | ADDRESS   |  |
| No   |  | 579 34 5808  |  | Albert A. Rabida Son same as item 13   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:  |  | 19. IMMEDIATE CAUSE (a)  |  | 20. DUE TO, OR AS A CONSEQUENCE OF   |  | 21. APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH                    |  |
| 4140   |  | CARDIAC ARREST   |  | ARTERIOCLEROTIC HEART DIS  |  | 1 HOUR 4 YEARS  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.   |  | (b)  |  | (c)  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | 22b. DATE SIGNED   |  | 22c. DATE SIGNED   |  |   |  |
| above (I) (we) (we did not) view the body after death.   |  | 4/25/83  |  | 4/27/83  |  |   |  |
| 22d. SIGNATURE   |  | DEGREE   |  | ATTENDING PHYSICIAN  |  | MEDICAL STAFF PHYSICIAN <input type="checkbox"/>                    |  |
| Thos G. WARD M.D.  |  |  |  | X  |  |   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22f. ADDRESS   |  | 22g. ADDRESS   |  |   |  |
| Thos G. WARD   |  | 6116 ROBINWOOD Bethesda, Md 20814  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |
| Burial/Removal   |  | April 29, 1983   |  | Roselawn Cemetery  |  | Pueblo, Colorado  |  |
| 24. FUNERAL DIRECTOR   |  | 24b. DATE REC'D. BY REGISTRAR  |  | 24c. REGISTRAR'S SIGNATURE   |  |   |  |
| ROBERT A. PUMPHREY FUNERAL HOMES, P.A. ROCKVILLE, MARYLAND   |  | MAY 2 1983   |  | John J. Carver   |  |   |  |

1. The purpose of this contract is to provide for the purchase of the following items:

| Item No. | Description | Quantity | Unit Price | Total Price |
|----------|-------------|----------|------------|-------------|
| 1        | ...         | ...      | ...        | ...         |
| 2        | ...         | ...      | ...        | ...         |
| 3        | ...         | ...      | ...        | ...         |
| 4        | ...         | ...      | ...        | ...         |
| 5        | ...         | ...      | ...        | ...         |
| 6        | ...         | ...      | ...        | ...         |
| 7        | ...         | ...      | ...        | ...         |
| 8        | ...         | ...      | ...        | ...         |
| 9        | ...         | ...      | ...        | ...         |
| 10       | ...         | ...      | ...        | ...         |

2. The total price for the items listed above is \$...

3. The contractor shall deliver the items to the following address: ...

4. The contractor shall be responsible for the shipping and handling charges.

5. The contractor shall provide a bill of lading for the items.

6. The contractor shall provide a certificate of origin for the items.

7. The contractor shall provide a certificate of conformity for the items.

8. The contractor shall provide a certificate of inspection for the items.

9. The contractor shall provide a certificate of acceptance for the items.

10. The contractor shall provide a certificate of completion for the items.



1. The purpose of this contract is to provide for the purchase of the following items:

| Item No. | Description | Quantity | Unit Price | Total Price |
|----------|-------------|----------|------------|-------------|
| 1        | ...         | ...      | ...        | ...         |
| 2        | ...         | ...      | ...        | ...         |
| 3        | ...         | ...      | ...        | ...         |
| 4        | ...         | ...      | ...        | ...         |
| 5        | ...         | ...      | ...        | ...         |
| 6        | ...         | ...      | ...        | ...         |
| 7        | ...         | ...      | ...        | ...         |
| 8        | ...         | ...      | ...        | ...         |
| 9        | ...         | ...      | ...        | ...         |
| 10       | ...         | ...      | ...        | ...         |

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9. The contractor shall provide a certificate of acceptance for the items.

10. The contractor shall provide a certificate of completion for the items.



Item #7a Film G579 5/10/83 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 5 0

REG. NO.

|  |   |   |  |  |
|--|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>X</b> <b>LENA</b> <b>RABINEAU</b>  |   | 2. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-15-1983</b>  |  | 2b. HOUR<br><b>3:00</b>  |
| 3. SEX<br><b>FEMALE</b>  | 4. RACE<br><b>WHITE</b>                       | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4-15-1922</b>  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>91</b> YRS.                          | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>X Montgomery County MD.</b>     |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA, MD</b>   |   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN</b>                                |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>D.C.</b>  |   | 13c. CITY OR TOWN<br><b>Washington</b>  | 13d. STREET ADDRESS<br><b>5432 Connecticut Ave. NW</b>                     |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Emanuel Goldstein</b>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Rachel Sachs</b>  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>577-84-2212</b>  | 17. INFORMANT ADDRESS<br><b>Norman Rabineau; 117 Eldrid Dr., SSpG, Md.</b> |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>5335</b> IMMEDIATE CAUSE (a) <b>Perforated Ulcer</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 day</b>                         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Porphyrina</b>  |   |   |  |  |
| 19a. DATE OF OPERATION<br><b>4/13</b>  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>4/13</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>4/13</b>   |  |  |
| 21f. LOCATION<br>STREET<br><b>4/13</b>   |   | 21g. CITY OR TOWN<br>COUNTY<br>STATE  |  |  |
| 22a. I certify that (1) (his) hospital attended the deceased from <b>4/13</b> , 19 <b>83</b> , to <b>4/15</b> , 19 <b>83</b> , that (1) (we) lost saw the deceased alive on <b>4/14</b> , 19 <b>83</b> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.    |   |   |  |  |
| 22b. SIGNATURE<br><b>Raymond Bass</b>  |   | 22c. DATE SIGNED<br><b>4-15-83</b>  |  | 22d. ADDRESS<br><b>3929 Ferrara Wheaton Md 20906</b>                                 |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>4-17-1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Adas Israel Cem.</b>                        |
| 23d. LOCATION<br>CITY OR TOWN<br><b>Washington, D.C.</b>   |   | 23e. STATE<br><b>D.C.</b>   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 19 1983</b>   |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 11051

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
|---|--|--|---|--|--|---|--|--|---|--|--|---------------------|--|--|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |  | 2a. DATE OF DEATH   |  |  | MONTH   |  |  | DAY   |  |  | YEAR                |  |  | 2b. HOUR  |  |  |
| Claribel K. Ragsdale  |  |  | 4   |  |  | 19  |  |  | 83  |  |  | 3                   |  |  | M   |  |  |
| 3. SEX  |  |  | 4. RACE   |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  | 7. IF UNDER 1 YEAR  |  |  | 7. IF UNDER 24 HRS.                             |  |  |
| female  |  |  | white   |  |  | Aug. 11 1900  |  |  | 82  |  |  | YRS.                |  |  | MONTHS  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |                     |  |  |   |  |  |
| Georgia   |  |  | USA   |  |  |   |  |  | Montgomery MD   |  |  |                     |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH   |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |                     |  |  |   |  |  |
| Silver Spring   |  |  | 406 Dale Drive  |  |  | Homemaker   |  |  | own home  |  |  |                     |  |  |   |  |  |
| 13a. STATE  |  |  | 13b. COUNTY   |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS |  |  |   |  |  |
| Maryland  |  |  | Montgomery  |  |  | Silver Spring   |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 406 Dale Drive      |  |  | 20910   |  |  |
| 14. FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| FIRST MIDDLE LAST   |  |  | FIRST MIDDLE LAST   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| Horace H. Kemp  |  |  | Nora Watson   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)   |  |  | 17. INFORMANT   |  |  | ADDRESS   |  |  |                     |  |  |   |  |  |
| N/A   |  |  | N/A   |  |  | 213-56-2643   |  |  | Warner B. Ragsdale-husband-(same as 13e)                            |  |  |                     |  |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)   |  |  |   |  |  |   |  |  |   |  |  |                     |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH |  |  |
| PART 1. DEATH WAS CAUSED BY:  |  |  |   |  |  |   |  |  |   |  |  |                     |  |  | 5-6 days  |  |  |
| 4860 IMMEDIATE CAUSE (a) <u>Terminal pneumonia</u>  |  |  |   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| (c)   |  |  |   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Cerebral &amp; generalized arteriosclerosis</u>   |  |  |   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |                     |  |  |   |  |  |
|   |  |  |   |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |                     |  |  |   |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |                     |  |  |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |  |                     |  |  |   |  |  |
|   |  |  |   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>June 19 61</u> to <u>4-19 19 83</u> , that (I) (we) last saw the deceased alive on <u>4-16 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death. |  |  |   |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| 22b. SIGNATURE  |  |  | DEGREE  |  |  | ATTENDING MEDICAL STAFF<br>PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>               |  |  | 22c. DATE SIGNED  |  |  |                     |  |  |   |  |  |
| <u>Jason Geiger, MD</u>   |  |  |   |  |  |   |  |  | 4-19-83   |  |  |                     |  |  |   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| Jason Geiger, MD  |  |  | 8830 Cameron St., Silver Spring, Md.  |  |  |   |  |  |   |  |  |                     |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  |  | 23b. DATE   |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |  |                     |  |  |   |  |  |
| Burial  |  |  | 4-21-1983   |  |  | Parklawn Cemetery   |  |  | Rockville Montgomery Md.  |  |  |                     |  |  |   |  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  |  | 24b. ADDRESS  |  |  | 25a. DATE REC'D. BY REGISTRAR   |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |                     |  |  |   |  |  |
| Hines/Rinaldi Funeral Home  |  |  | 11800 N.H. Ave.,<br>Silver Spring, Md.  |  |  | APR 19 1983   |  |  | <u>John J. Connelley</u>  |  |  |                     |  |  |   |  |  |

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MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 26



STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

83 11 052

 FOR  
 1 - STATE  
 REGISTRAR

REG. NO.

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Charles R Ramsburg</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 30 83</b>                                   |  | 2b. HOUR<br><b>11:31 p</b>  |
| 3. SEX<br><b>M</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 31, 1916</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b><br>YRS. MONTHS DAYS HOURS MIN.  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Olney Md</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br><b>Montgomery General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Ret. milkman</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>dairy</b>  |   |
| 13a. STATE<br><b>Md</b>   |   |   | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Silver Spring</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Calvin Ross Ramsburg</b>   |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Sadie Burdette</b>                  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>no</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>220 14 0482</b>  |   | 17. INFORMANT ADDRESS<br><b>AB Eleanor Ramsburg, same as above</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>cardiopulmonary Arrest</b><br><b>4149</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |   |   |   |  |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>stroke - old Subdural Hematoma, undiagnosed</b>   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 19c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 20b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 20c. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |   |
| 21a. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21b. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21c. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/23/83</b> to <b>4/30/83</b> , that (I) (we) lost saw the deceased alive on <b>4/30/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |   |   |   |  |   |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Norman A. Liban</b>   |   | 22c. ADDRESS<br><b>8001 Wisconsin Ave. Bethesda, Md</b>   |   | 22d. DATE SIGNED<br><b>4/30/83</b>   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>May 3, 1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Union Cemetery</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Burtonsville, Md</b>   |   | 24. FUNERAL DIRECTOR<br>NAME<br><b>Donaldson Funeral Home, Laurel, Md</b>   |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 11 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |   |  |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. This permit removes carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |                              |   |   |  |  |  |                 |   | 8 3 1 1 0 5 3                                |          |  |
|--|--|------------------------------|---|---|--|--|--|-----------------|---|--|----------|--|
| 1. FOR STATE REGISTRAR   |  |                              |   |   |  |  |  |                 |   | REG. NO.                                     |          |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |                              | FIRST MIDDLE LAST   |   |  | 2a. DATE OF DEATH  |  |                 | MONTH DAY YEAR  |  | 2b. HOUR |  |
| JESSIE Marshall Randolph   |  |                              |   |   |  | 4/21/83  |  |                 |   |  | 250 AM   |  |
| 3. SEX   |  | 4. RACE                      |   | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  | IF UNDER 1 YEAR |   | IF UNDER 24 HRS                              |          |  |
| FEMALE   |  | BLACK                        |   | MONTH DAY YEAR  |  | 69   |  | MONTHS DAYS     |   | HOURS MIN.                                   |          |  |
| 7a. BIRTHPLACE<br>(COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY? |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |                 |   |  |          |  |
| WASHINGTON, D.C.   |  | U.S.A.                       |   |   |  | TAKOMA PARK MD   |  |                 |   |  |          |  |
| 11. CITY OR TOWN OF DEATH  |  |                              | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF LAST WORKING YEAR)          |  |                 | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |          |  |
| TAKOMA PARK MD   |  |                              | WASHINGTON Adventist Hosp   |   |  | SECRETARY  |  |                 | PRIVATE   |  |          |  |
| 13a. STATE   |  |                              | 13b. COUNTY   |   |  | 13c. CITY OR TOWN  |  |                 | 13d. INSIDE CITY LIMITS?  |  |          |  |
| MARYLAND   |  |                              | MONTGOMERY  |   |  | TAKOMA PARK  |  |                 | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |          |  |
| 14. FATHER'S NAME<br>(FIRST MIDDLE LAST)   |  |                              | 15. MOTHER'S MAIDEN NAME<br>(FIRST MIDDLE LAST)   |   |  | 13e. STREET ADDRESS  |  |                 | 20912   |  |          |  |
| John Stockton  |  |                              | Sallie Webb   |   |  | 7710-Maple Avenue  |  |                 |   |  |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  |                              | 16b. SOCIAL SECURITY NO.  |   |  | 17. INFORMANT  |  |                 | ADDRESS   |  |          |  |
| NO   |  |                              | 577-485254  |   |  | LEONARD Randolph   |  |                 | 7710 Maple Ave TAKOMA PARK MD                                       |  |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) CARDIO RESPIRATORY Arrest<br>1889<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) CARCINOMA of The Bladder<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |                              |   |   |  |  |  |                 |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 18.   |  |                              |   |   |  |  |  |                 |   |  |          |  |
| 19a. DATE OF OPERATION   |  |                              | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  | 20a. AUTOPSY?  |  |                 | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |          |  |
|  |  |                              |   |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |  |                 | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |          |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |                              | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |  |                 |   |  |          |  |
|  |  |                              |   |   |  |  |  |                 |   |  |          |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |                              | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |                 |   |  |          |  |
|  |  |                              |   |   |  |  |  |                 |   |  |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 3-30, 1983, to 4-20, 1983, that (I) (we) lost the deceased alive on 4-20, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |                              |   |   |  |  |  |                 |   |  |          |  |
| 22b. SIGNATURE<br>Philip W. Roth MD, PC  |  |                              |   |   |  | DEGREE   |  |                 | 22c. DATE SIGNED  |  |          |  |
|  |  |                              |   |   |  |  |  |                 | 4/21/83   |  |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |                              |   |   |  | 22e. ADDRESS   |  |                 |   |  |          |  |
| Philip W. Roth MD, PC  |  |                              |   |   |  | 818-18th St. N.W.  |  |                 |   |  |          |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)   |  |                              | 23b. DATE   |   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |                 | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |          |  |
| Burial   |  |                              | 4/25/83   |   |  | Maryland Nat.  |  |                 | LAURA MD.   |  |          |  |
| 24. FUNERAL DIRECTOR<br>R & H HORTON Co. 600 Kennedy St  |  |                              |   |   |  | 25a. DATE REC'D. BY REGISTRAR  |  |                 | 25b. REGISTRAR'S SIGNATURE  |  |          |  |
|  |  |                              |   |   |  | APR 27 1983  |  |                 | John E. ...   |  |          |  |

MEDICAL CERTIFICATION



20X2001

FILED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and involved.

## MEDICAL CERTIFICATION

#25a, per call w/F.H. 4/8/83 kam

FOR STATE REGISTRAR

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 83 11054

|   |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |
|---|--|--|--|--|--|---|--|--|--|------------------|-----|------------|----------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | FIRST  |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH  |  | MONTH            | DAY | YEAR       | 2b. HOUR |  |
| Solomon   |  | Rappaport  |  |  |  |   |  | 4-7-83   |  | 5:45             |     | A.M.       |          |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS. |     |            |          |  |
| Male  |  | White  |  | 7 07 94  |  | 88  |  | MONTHS   |  | DAYS             |     | HOURS MIN. |          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |                  |     |            |          |  |
| Russia  |  | USA  |  |  |  | Montgomery  |  |  |  |                  |     |            |          |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |                  |     |            |          |  |
| Silver Spring   |  | Holy Cross Hospital  |  | PHARMACIST   |  | DRUG STORE  |  |  |  |                  |     |            |          |  |
| 13a. STATE  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS  |  |                  |     |            |          |  |
| PENNSYLVANIA  |  | PHILADELPHIA   |  | PHILADELPHIA   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 5229 WHITAKER AVENUE   |  |                  |     |            |          |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |                  |     |            |          |  |
| JACOB   |  | MATILDA  |  |  |  |   |  |  |  |                  |     |            |          |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT  |  |   |  |  |  |                  |     |            |          |  |
| NO  |  | 176-28-7232  |  | SHELDON RAPPAPORT, SILVER SPRING, MARYLAND   |  |   |  |  |  |                  |     |            |          |  |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c).)   |  | 19. DATE OF OPERATION  |  | 19a. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                  |     |            |          |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                  |     |            |          |  |
| IMMEDIATE CAUSE (a)   |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |
| 5850  |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |
| (b)   |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |
| DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |
| (c)   |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:                  |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |  |                  |     |            |          |  |
|   |  | HOUR A.M. MONTH DAY YEAR   |  |  |  |   |  |  |  |                  |     |            |          |  |
|   |  | P.M. 19  |  |  |  |   |  |  |  |                  |     |            |          |  |
| 21d. INJURY OCCURRED  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION  |  |   |  |  |  |                  |     |            |          |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | STREET   |  | CITY OR TOWN  |  | COUNTY   |  | STATE            |     |            |          |  |
|   |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |
| 22a. I certify that (I) (this hospital) attended the deceased from  |  | 22b. DATE  |  | 22c. NAME OF CEMETERY OR CREMATORY   |  | 22d. LOCATION   |  |  |  |                  |     |            |          |  |
| saw the deceased alive on   |  | 4/6  |  | MONTEFIORE CEMETERY  |  | ABINGTON, MONTGOMERY, PA.   |  |  |  |                  |     |            |          |  |
| about (I) (we) (did not view the body after death).   |  | 19 83  |  |  |  |   |  |  |  |                  |     |            |          |  |
| 22a. SIGNATURE  |  | 22b. DEGREE  |  | 22c. DATE SIGNED   |  |   |  |  |  |                  |     |            |          |  |
| MARIC H. ELG, M.D.  |  | 4/7/83   |  | 4/7/83   |  |   |  |  |  |                  |     |            |          |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |  |  |                  |     |            |          |  |
| MARIC H. ELG, M.D.  |  | 9801 Georgia Ave. Silver Spring, Md  |  |  |  |   |  |  |  |                  |     |            |          |  |
| 23a. BURIAL, CREMATION, REMOVAL   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION   |  |  |  |                  |     |            |          |  |
| BURIAL Cremation  |  | 4/10/1983  |  | MONTEFIORE CEMETERY  |  | ABINGTON, MONTGOMERY, PA.   |  |  |  |                  |     |            |          |  |
| 24. FUNERAL DIRECTOR  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |  |  |                  |     |            |          |  |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME  |  | APR 7 1983   |  | John J. Connel   |  |   |  |  |  |                  |     |            |          |  |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C.  |  |  |  |  |  |   |  |  |  |                  |     |            |          |  |

WILLIAM

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

|   |  |  |  |   |   |  |  |  |  |
|---|--|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>ERNEST MCDOWELL REAGAN, JR</b>  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 7 1983</b> |   |   | 2b. HOUR<br>a<br><b>1:57</b><br>M  |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>DECEMBER 9 1924</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>58</b><br>YRS.   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NORTH CAROLINA</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>U.S. NAVY</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>SOUTH CAROLINA</b>   |  | 13b. COUNTY<br><b>CHARLESTON</b>   |  | 13c. CITY OR TOWN<br><b>CHARLESTON</b>  |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br><b>1607 DICKENS STREET</b> 99999  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>ERNEST MCDOWELL REAGAN</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ZOLA ROWE</b> |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>240-22-6313</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>NANCY H. REAGAN, 1607 DICKENS STREET, CHARLESTON, SC 29407</b>   |   |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>ESOPHAGEAL CANCER</b><br><b>1509</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____     |  |  |  |   |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>MARCH 2</b> , 19 <b>83</b> , to <b>APRIL 7</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>APRIL 7</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><i>P. Massimiano</i>  |  |  |  |   |   | DEGREE <i>MD</i><br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/7/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>P. MASSIMIANO, LT, MC, USNR</b>   |  |  |  | 22e. ADDRESS <b>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814</b>  |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>SPECIFY<br><b>REMOVAL</b>  |  | 23b. DATE<br><b>4-9-83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>J.H. STUHR F/HOME</b>  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>CHARLESTON S.C.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Marshall's Funeral Home</b><br><b>4217 9th St. NW, Washington, D.C.</b>   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b>  |   |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP \_\_\_\_\_

DHMH - 16 50M 4/82  
(VRA 15, 4)

Item 4 per phone 5/9/83 dad

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 5 6

REG. NO.

|   |  |   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>MAE - REASON</b>                       |  |   | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>28</b> YEAR <b>83</b> |   |  | 2b. HOUR<br><b>10:10 PM</b>   |  |  |  |
| 3. SEX<br><b>F</b>  |  | 4. RACE<br><b>Caucasian</b>   |  | 5. DATE OF BIRTH<br>MONTH <b>8</b> DAY <b>16</b> YEAR <b>09</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>74</b> YRS.   |  | IF UNDER 1 YEAR<br>MONTHS <b>1</b> DAYS <b>1</b>         |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>VA</b>                        |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                             |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>FAIRLAWN N. A</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK) <b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>     |  |
| 13a. STATE<br><b>MD</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>15324 Aylesbury St., 20904</b> |  |
| 14. FATHER'S NAME<br>FIRST <b>HOMER</b> MIDDLE <b>JACK</b> LAST <b>AUSTIN</b> |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>LIZY</b> MIDDLE <b>L</b> LAST <b>HONS</b>  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>NO</b>  |  |   |  |  |  |
| 16b. SOCIAL SECURITY NO.<br><b>229-82-1126</b>                                |  | 17. INFORMANT<br>ADDRESS<br><b>Mary R. Hilton-dau- (same as 13e)</b>  |  |   |  |   |  |  |  |

|  |  |   |  |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary arrest</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4/28</b> |  |
| 4130<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b) <b>Pericardial Angina</b>                               |  |
|  |  | (c) <b>Lupus like illness</b>                               |  |

|  |  |  |  |
|--|--|--|--|
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Parkinson Dis, HBP, osteoarthritis, Hip Fr</b>  |  |  |  |
| 19a. DATE OF OPERATION<br><b>3/17/83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Hip Fracture (R)</b>  |  |
| 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>      |  |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)<br><input type="checkbox"/>   |  | 21b. TIME OF INJURY<br>HOUR <b>A.M.</b> MONTH <b>2</b> DAY <b>23</b> YEAR <b>1983</b>  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>Fall AT HOME</b>   |  | 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                       |  |
| 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>Home</b>  |  | 21f. LOCATION<br>STREET <b>15324 Aylesbury St.</b> CITY OR TOWN <b>Silver Spring</b> COUNTY <b>Montgomery</b> STATE <b>MD</b>              |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/17</b> , 19 <b>83</b> , to <b>4/28</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>4/28</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not) (did not) view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Arthur J. Brown</b>   |  | DEGREE   |  |
| 22c. DATE SIGNED<br><b>4/28/83</b>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Sutton, A</b>  |  | 22e. ADDRESS<br><b>1814 Prince Philip P. Hwy, Md.</b>  |  |

|  |  |                                 |  |  |  |   |  |
|--|--|---------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(IF DIFF.) <b>BURIAL</b>                                    |  | 23b. DATE<br><b>MAY 2, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>FAMILY CEMETERY</b> |  | 23d. LOCATION<br>(IF OR TOWN) <b>BIG STONE GAP, VA.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>HINES, RINALDI F.H.</b> ADDRESS <b>11800 NEW HAMPSHIRE AVE</b> |  |                                 |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 3, 1983</b>          |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>     |  |



COPIES  
11/11/11

WILLIAM E. YAM  
JAMES A. YAM

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BP

DHMH - 16 50M 4/82  
(VRA 15, 4)1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 5 7

REG. NO.

|  |   |   |  |   |   |
|--|---|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>WILLIAM H REED</b>   |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-27-83</b>  |   | 2b. HOUR<br><b>11:40am</b>                              |
| 3. SEX<br><b>male</b>  | 4. RACE<br><b>white</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>3-9-12</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b> YRS.   |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Chicago, Ill.</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK OR MOST OF WORKING LIFE)<br><b>Ret. Police-Metro.</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Police Dept</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Mont.</b>   | 13c. CITY OR TOWN<br><b>Wheaton</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Unknown Reed</b>  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Unknown</b>  |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |   | 16b. SOCIAL SECURITY NO.<br><b>214 03 8627</b>  |  | 17. INFORMANT<br><b>Silver Spring, Md. 20902</b><br><b>Mildred C. Reed-wife 16800 Ga. Ave</b>   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiac arrest.</b><br><b>4/00</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Major Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 hrs.</b> |   |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.  |   |   |  |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) this hospital attended the deceased from <b>4/27</b> 19 <b>83</b> , to <b>4/27</b> 19 <b>83</b> , that (we) lost saw the deceased alive on <b>4/27</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.   |   |   |  |   |   |
| 22b. SIGNATURE<br><b>James R. Coleman MD.</b>  |   | DEGREE  |  | 22c. DATE SIGNED<br><b>4-27-83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JAMES R. COLEMAN</b>   |   | 22e. ADDRESS<br><b>9241 COLUMBIA BLVD<br/>SILVER SPRING, MD. 20910</b>  |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Cremation</b>   | 23b. DATE<br><b>4-28-83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee's Crematory</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D.C. 20002</b>                     |   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Lee Funeral Home Washington, D.C. 20002</b>   |   | 25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>MAY 3 1983</b>  |  |   |   |

MEDICAL CERTIFICATION

See Journal Home Page for more information

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 5 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Ruth C. REIGLE</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 29 83</b>                            |  | 2b. HOUR<br><b>11:38 PM</b>                              |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Jan. 18 1907</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b>   | YRS. MONTHS DAYS HOURS MIN.                              |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD</b>                  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SHADY GROVE ADVENTIST HOSPITAL</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OR WORK FOR MOST OF WORKING LIFE)<br><b>Clerk</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>State worker</b> |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><b>Maryland Montgomery Rockville</b>   |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   | 13c. STREET ADDRESS<br><b>20851 13113 Twinbrook Parkway</b>                      |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Harry Clark</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mabel Brubaker</b>  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>190-26-6491</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>12229 Village Square Tr. Rockville, Maryland</b>      |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiopulmonary Arrest</b><br><b>2500</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <b>Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Diabetes Mellitus</b> |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH             |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Rt. Hip Fracture, and Rt. Shoulder Fracture</b>  |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>4/27/83</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Hip, Shoulder Fracture</b>   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)                                   |  |  |  |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/29/83</b> 19 <b>83</b> to <b>4/29</b> 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/29/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Montague Blunden</b>   |  | DEGREE<br><b>M.D.</b>   |  | 22c. DATE SIGNED<br><b>4/30/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Montague Blunden MD</b>   |  | 22e. ADDRESS<br><b>5640 Shields Drive, Bethesda, Md 20814</b>   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>5/4/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Hummelstown Cemetery</b>                    |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Hummelstown, Pennsylvania</b>  |  | 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland</b>                                     |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 6 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John G. ...</b>  |  |  |  |

MEDICAL CERTIFICATION

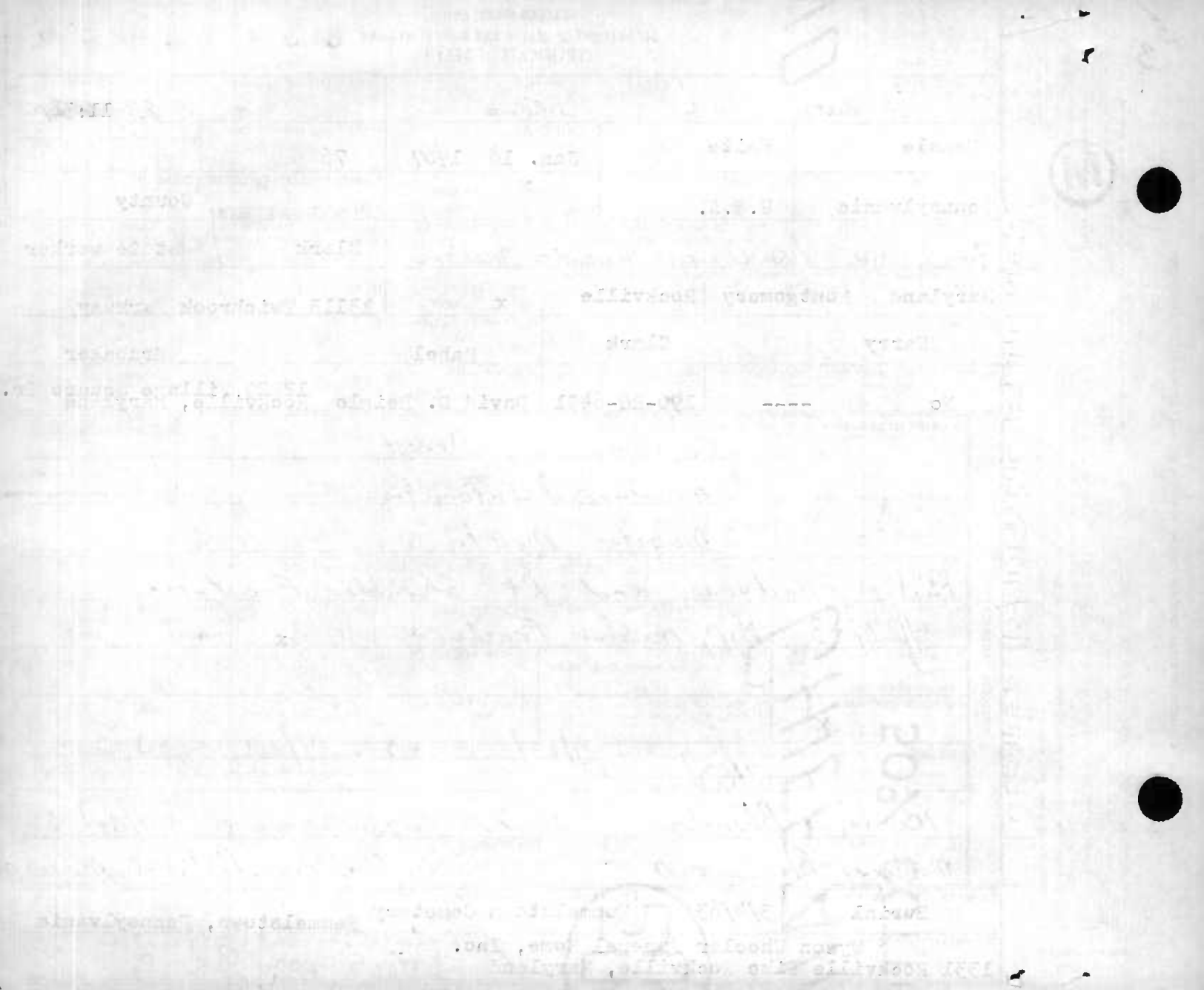
CLEARED BY MEDICAL EXAMINER

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





Item #6 Film G579 5/10/83 rc  
STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. 83 11059

|  |  |   |  |  |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
|--|--|---|--|--|--|---|--|--------------------------------------|--|------|--|--------------------------------|--|------|--|--------------------|--|---------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST   |  | MIDDLE   |  | LAST  |  | 2a. DATE OF DEATH                    |  |      |  | MONTH                          |  | DAY  |  | YEAR               |  | 2b. HOUR            |  |
| Lillian  |  | Richardson  |  |  |  |   |  | 04-16-83                             |  |      |  |                                |  |      |  |                    |  | 2 <sup>00</sup> PM  |  |
| 3 SEX  |  | 4 RACE  |  | 5. DATE OF BIRTH   |  | MONTH   |  | DAY                                  |  | YEAR |  | 6 AGE (IN YEARS LAST BIRTHDAY) |  | YRS. |  | 7. IF UNDER 1 YEAR |  | 8. IF UNDER 24 HRS. |  |
| Female   |  | NEGRO   |  | Sept   |  | 29  |  | 1909                                 |  |      |  | 74-73                          |  |      |  | MONTHS             |  | DAYS                |  |
| 9. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>     |  | WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH |  |      |  |                                |  |      |  |                    |  |                     |  |
| S. C.  |  | U.S.A.  |  |  |  |   |  | Montgomery County                    |  |      |  |                                |  |      |  |                    |  |                     |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)               |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| Takoma Pk.   |  | Sligo Nursing Home  |  | Cook   |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 13a. STATE   |  | 13b. COUNTY   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS                  |  |      |  |                                |  |      |  |                    |  |                     |  |
| Maryland   |  | P.G.  |  | Seat Pleasant  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>           |  | 7403 Calder Drive                    |  |      |  |                                |  |      |  |                    |  |                     |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| (Unknown)  |  | Kennedy   |  | Ida  |  | Jackson   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  | ADDRESS   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| No   |  | 251-38-4068   |  | Vivian Richardson  |  | 4471 Dorset Circle<br>Decatur, Georgia  |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 18. CAUSE OF DEATH   |  | PART 1. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 4140   |  | Cordia-Rosa Arrest  |  |  |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (b)   |  | DUE TO, OR AS A CONSEQUENCE OF   |  | (c)   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
|  |  | Chronic Brain Syndrome  |  |  |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:   |  |   |  |  |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?                |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
|  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                      |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2) |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-16-83 to 4-16-83, that (I) (we) last saw the deceased live on 4-16-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. |  | 22b. SIGNATURE  |  | DEGREE   |  | 22c. DATE SIGNED  |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
|  |  | R.H. Sandstrom MD   |  |  |  | 4-16-83   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS  |  |  |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| R.H. Sandstrom MD  |  | 7701 Connel Ave Trkr, Md  |  |  |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                                    |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| Burial   |  | 4/23/83   |  | Pal Metto  |  | Richland County S. C.   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| 24. FUNERAL DIRECTOR<br>NAME   |  | 25a. DATE REC'D. BY REGISTRAR   |  | 25b. REGISTRAR'S SIGNATURE   |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |
| Morrow & Woodford, Inc.<br>1622 11th St., N.W. Wash., D.C.   |  | APR 27 1983   |  | John J. Canfield   |  |   |  |                                      |  |      |  |                                |  |      |  |                    |  |                     |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, medical attention must be noted at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |  |  | 8 3 1 1 0 6 0 |
|---|--|---|--|---|--|---|--|--|--|---------------|
| 1. FOR STATE REGISTRAR  |  |   |  |   |  |   |  |  |  | REG. NO.      |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>George H. Riggs, Jr.</b>  |  |   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 17, 1983</b>                   |   |  | 2b. HOUR<br><b>9:03pm</b>  |  |               |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>WHITE</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 3, 1904</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>78</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |               |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Md.</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD                             |  |  |  |               |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Architect</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Architecture</b>   |  |               |
| 13a. STATE<br><b>Md.</b>  |  | 13b. COUNTY<br><b>Mont.</b>   |  | 13c. CITY OR TOWN<br><b>Ashton</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>17530 New Hampshire Ave.</b>   |  |               |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>George H. Riggs</b>  |  |   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Cordelia - Duvall</b>      |   |  |  |  |               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Unk.</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>214-14-0473</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Eugene Riggs 17534 New Hampshire Ave.</b>                        |  |  |  |               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>metastatic adenocarcinoma - prob. lung</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 mos.</b> |  |   |  |   |  |   |  |  |  |               |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><b>Chronic bronchitis, COPD, chr. renal failure</b>  |  |   |  |   |  |   |  |  |  |               |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) |   |  |  |  |               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |  |  |               |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-17-1983</b> , 19 <b>79</b> , to <b>Apr. 17</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>4-17-1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did not) view the body after death.  |  |   |  |   |  |   |  |  |  |               |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Frederick Moomau, M. D.</b>   |  |   |  |   | 22c. ADDRESS<br><b>Olney Md.</b>   |   |  | 22c. DATE SIGNED<br><b>4-18-83</b>   |  |               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b>  |  |   | 23b. DATE<br><b>APR. 18, 1983</b>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lee Crematory</b>                     |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Washington, D. C.</b> |  |  |               |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Francis H. Barber Laytonsville, Md. 20879</b>  |  |   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 21 1983</b>                            |   |  |  |  |               |
|   |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                               |   |  |  |  |               |

x

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  | REG. NO. 8311061  |  |   |  |
|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Shirley Marie Robertson   |  |   |  | April 28 '83 1 P M  |  |   |  |
| 3. SEX Female  |  | 4. RACE White   |  | 5. DATE OF BIRTH MONTH DAY YEAR March 1 1936  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland   |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH Gaithersburg   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 8309 Fairhaven Drive |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret'd   |  | 12b. KIND OF BUSINESS OR INDUSTRY Nursing - Canning Factory   |  |
| 13a. STATE Md.   |  | 13b. COUNTY Montgomery  |  | 13c. CITY OR TOWN Gaithersburg  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST John - Best  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Marie Earp   |  | 13e. STREET ADDRESS 8309 Fairhaven Drive  |  | 20877   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 217-32-4286  |  | 17. INFORMANT ADDRESS 8309 Fairhaven Dr.  |  | Ray Allen Montgomery Gaithersburg, Md. 20877  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Kent Failure</u> 4029   |  |   |  |   |  |   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertension</u> (c) <u>COPD</u>   |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Dec 9 1974</u> to <u>4/14 1983</u> , that (I) (we) lost saw the deceased alive on <u>4/14 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. |  |   |  |   |  |   |  |
| 22b. SIGNATURE <u>William Daniels</u>  |  |   |  | DEGREE <u>MD</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <u>4/28/83</u>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WILLIAM DANIELS</u>   |  |   |  | 22e. ADDRESS <u>13-15 EAST DEER PARK DR. GAITHERSBURG, MD 20877</u>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>   |  | 23b. DATE <u>4/29/83</u>  |  | 23c. NAME OF CEMETERY OR CREMATORY <u>Lee's Crematory</u>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>Washington, D. C.</u>  |  |
| 24. FUNERAL DIRECTOR <u>Robert H. Sandison</u> <u>316 E. Diamond Ave.</u> <u>Gaithersburg, Md. 20877</u>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <u>MAY 3 1983</u> REGISTRAR'S SIGNATURE <u>John J. Connel</u>   |  |   |  |

BP

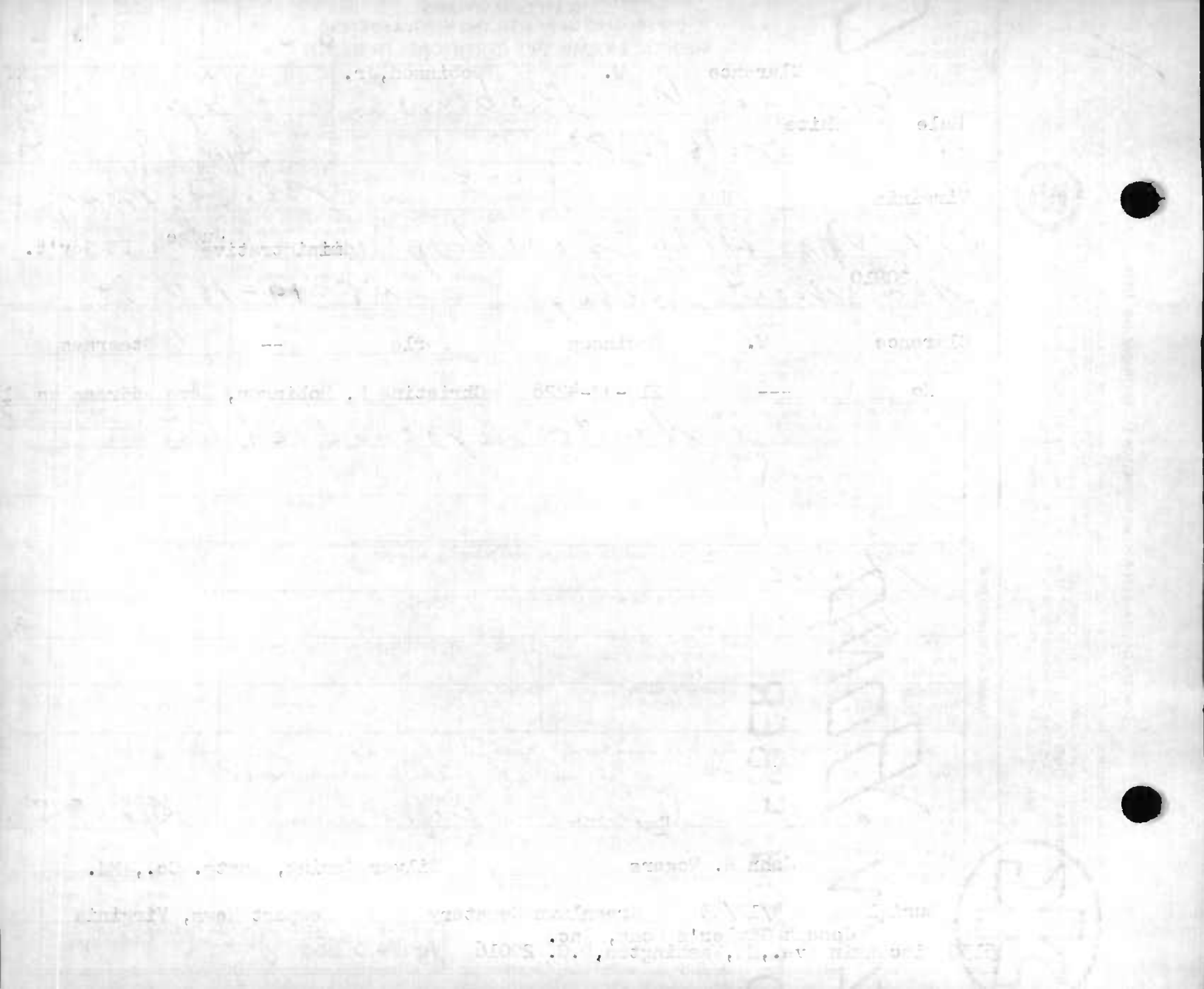


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PART 1 OF THIS FORM. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (1))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |  |  |  |  | REG. NO. 11062  |  |
|--|--|----------------------|--|--|--|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |                      |  |  |  |  |  |  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <b>Clarence</b> MIDDLE <b>W.</b> LAST <b>Robinson, Jr.</b>  |  |                      |  |  |  |  |  |  |  | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>April</b> DAY <b>19</b> YEAR <b>1983</b> |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH MONTH <b>April</b> DAY <b>16</b> YEAR <b>1902</b>   |  | 6. AGE (IN YEARS) MONTHS <b>80</b> DAYS <b>02</b> HOURS <b>00</b> MIN. <b>00</b> |  | 7c. DATE PRONOUNCED DEAD <b>April 19</b> 19 <b>83</b>  |  | 2d. HOUR <b>PM</b>  |  |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Virginia</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>St. Louis</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Administrative</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>  |  |
| 13a. STATE <b>MD</b>   |  |                      |  | 13b. CITY OR TOWN <b>Montg</b>   |  |  |  | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 13d. STREET ADDRESS <b>F319-16th St</b>   |  |
| 14. FATHER'S NAME FIRST <b>Clarence</b> MIDDLE <b>W.</b> LAST <b>Robinson</b>  |  |                      |  | 15. MOTHER'S MAIDEN NAME FIRST <b>Perle</b> MIDDLE <b>--</b> LAST <b>Stearnes</b>  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>219-42-4228</b>  |  |  |  | 17. INFORMANT ADDRESS <b>Christine P. Robinson, Same address as #1</b>   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4291 Acute Myocardial Infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |  |                      |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>None</b>   |  |                      |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                              |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |  |                      |  | TITLE (SPECIFY) <b>Dep.</b> M.D.   |  |  |  | MEDICAL EXAMINER <b>Apr 19, 1983</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>  |  |                      |  | ADDRESS <b>Silver Spring, Montg. Co., Md.</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>4/12/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>                     |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Newport News, Virginia</b>   |  |
| 24. FUNERAL DIRECTOR NAME <b>Joseph Gawler's Sons, Inc.</b>  |  |                      |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b>                                 |  |  |  |   |  |
| 5130 Wisconsin Ave., NW, Washington, D.C. 20016  |  |                      |  |  |  | 25b. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>                                 |  |  |  |   |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be retained by the funeral director. Page 4 should be retained by the funeral director. Page 5 should be retained by the funeral director. Page 6 should be retained by the funeral director. Page 7 should be retained by the funeral director. Page 8 should be retained by the funeral director. Page 9 should be retained by the funeral director. Page 10 should be retained by the funeral director. Page 11 should be retained by the funeral director. Page 12 should be retained by the funeral director. Page 13 should be retained by the funeral director. Page 14 should be retained by the funeral director. Page 15 should be retained by the funeral director. Page 16 should be retained by the funeral director. Page 17 should be retained by the funeral director. Page 18 should be retained by the funeral director. Page 19 should be retained by the funeral director. Page 20 should be retained by the funeral director. Page 21 should be retained by the funeral director. Page 22 should be retained by the funeral director. Page 23 should be retained by the funeral director. Page 24 should be retained by the funeral director. Page 25 should be retained by the funeral director. Page 26 should be retained by the funeral director. Page 27 should be retained by the funeral director. Page 28 should be retained by the funeral director. Page 29 should be retained by the funeral director. Page 30 should be retained by the funeral director. Page 31 should be retained by the funeral director. Page 32 should be retained by the funeral director. Page 33 should be retained by the funeral director. Page 34 should be retained by the funeral director. Page 35 should be retained by the funeral director. Page 36 should be retained by the funeral director. Page 37 should be retained by the funeral director. Page 38 should be retained by the funeral director. Page 39 should be retained by the funeral director. Page 40 should be retained by the funeral director. Page 41 should be retained by the funeral director. Page 42 should be retained by the funeral director. Page 43 should be retained by the funeral director. Page 44 should be retained by the funeral director. Page 45 should be retained by the funeral director. Page 46 should be retained by the funeral director. Page 47 should be retained by the funeral director. Page 48 should be retained by the funeral director. Page 49 should be retained by the funeral director. Page 50 should be retained by the funeral director. Page 51 should be retained by the funeral director. Page 52 should be retained by the funeral director. Page 53 should be retained by the funeral director. Page 54 should be retained by the funeral director. Page 55 should be retained by the funeral director. Page 56 should be retained by the funeral director. Page 57 should be retained by the funeral director. Page 58 should be retained by the funeral director. Page 59 should be retained by the funeral director. Page 60 should be retained by the funeral director. Page 61 should be retained by the funeral director. Page 62 should be retained by the funeral director. Page 63 should be retained by the funeral director. Page 64 should be retained by the funeral director. Page 65 should be retained by the funeral director. Page 66 should be retained by the funeral director. Page 67 should be retained by the funeral director. Page 68 should be retained by the funeral director. Page 69 should be retained by the funeral director. Page 70 should be retained by the funeral director. Page 71 should be retained by the funeral director. Page 72 should be retained by the funeral director. Page 73 should be retained by the funeral director. 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Page 93 should be retained by the funeral director. Page 94 should be retained by the funeral director. Page 95 should be retained by the funeral director. Page 96 should be retained by the funeral director. Page 97 should be retained by the funeral director. Page 98 should be retained by the funeral director. Page 99 should be retained by the funeral director. Page 100 should be retained by the funeral director.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   | REG. NO.  |   |
|---|--|---|--|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Edna (nmn) Robinson</b>  |  |   |  | 2b. DATE OF DEATH MONTH DAY YEAR<br><b>April 22, 1983</b>                                       |   | 2b. HOUR<br><b>9:45 A</b>   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>White</b>  | 5. DATE OF BIRTH<br><b>October 3, 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.      |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Virginia</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>United States</b>   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County MD.</b>                            |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Clinical Center, Bethesda, Md.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   |
| 13a. STATE<br><b>Virginia</b>   |  | 13b. COUNTY<br><b>Russell</b>   | 13c. CITY OR TOWN<br><b>Swords Creek</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>Rt. 1, P.O. Box 319</b> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Dave Elkins</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Leona Strough</b>   |  |   |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>226-28-6867</b>  |  | 17. INFORMANT ADDRESS<br><b>Mr. Cecil B. Robinson (husband) same as patient</b>                 |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CENTRAL NERVOUS SYSTEM LYMPHOMA</b><br><b>2028</b> DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>DIFFUSE LYMPHOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 Years</b><br><b>3 Years</b>               |  |   |  |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____   |  |   |  |   |   |   |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                                |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |   |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>October 25, 1982</b> , to <b>April 22, 1983</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>April 22, 1983</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input type="checkbox"/> (not) view the body after death. |  |   |  |   |   |   |
| 22b. SIGNATURE<br><b>Bruce E. Johnson M.D.</b>  |  |   |  | 22c. DATE SIGNED<br><b>4/23/83</b>  |   | 22d. DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Bruce E. Johnson</b>  |  |   |  | 22f. ADDRESS<br><b>National Institutes of Health<br/>Clinical Center, Bethesda, Md. 20205</b>   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 26, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Greenhills Cemetery</b>                                |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Claypool Hill Virginia</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>ROBERT A. PUMPHREY FUNERAL<br/>HOMES, P.A., BETHESDA, MARYLAND</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 26 1983</b>   |   |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the local health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  |   |  |  |  |  |   |  |
|--|--|--|--|---|--|--|--|--|---|--|
| 1- FOR STATE REGISTRAR   |  |  |  |   | 8 3 1 1 0 6 4<br>REG. NO.  |  |  |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>William L. Robinson, Jr.  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 21, 1983  |  |  | 2b. HOUR<br>2:50P M  |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Black   |  | 5. DATE OF BIRTH<br>FEB. 22, 1909   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>73  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br>Wash. D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>Olney   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Montgomery General Hospital |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Truck Driver     |  | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br>Md.  |  |  |  |   | 13c. CITY OR TOWN<br>Gaithersburg  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>17801 Laytonsville Rd. 20877 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>William L. Robinson, Sr.   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Blanche Turner  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  |  |  |   | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>ADDRESS<br>Winona Monroe (Friend) same as #13                       |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>CARDIORESPIRATORY ARREST</u><br><u>1541</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>STATUS POST LAPAROTOMY FOR SMALL BOWEL OBSTRUCTION &amp; RECURRENT RECTAL CA.</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>ADHESIONS X RECURRENT RECTAL CARCINOMA</u><br>CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>20 M</u><br><u>24 Hs.</u> |  |  |  |   |  |  |  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.<br><u>ADVANCED ARTERIOSCLECTIC CARDIOVASCULAR DISEASE.</u>   |  |  |  |   |  |  |  |  |   |  |
| 19a. DATE OF OPERATION<br><u>4-20-82</u>   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>SMALL BOWEL OBSTRUCTION</u> |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                         |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)             |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-21-83</u> , 19 <u>83</u> , to <u>4-21-83</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>4-21-83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |  |   |  |
| 22b. SIGNATURE<br><u>Mario Diaz</u>  |  |  |  |   | DEGREE<br>M.D.<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  | 22c. DATE SIGNED<br><u>4-21-83</u>   |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Mario Diaz, M.D.  |  |  |  |   | 22e. ADDRESS<br>18111 Prince Phillip Dr., Olney, Md. 20832   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |  | 23b. DATE<br>4-26-83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Emory Grove Cem.   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Gaithersburg, Montg. Md.   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>George R. Snowden  |  |  |  |   | 24b. ADDRESS<br>Rockville, Md.<br>246 N. Washington St.  |  | 25. DATE REC'D. BY REGISTRAR<br>APR 28 1983  |  |   |  |

UNITED STATES DEPARTMENT OF THE ARMY  
HEADQUARTERS, ARMY  
WASHINGTON, D. C. 20315

11

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]  
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard memorandum format with several lines of text.]



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | 83 11065<br>REG. NO.  |  |  |  |  |  |  |  |
|--|--|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>MARGARET H. RODGER  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR<br>4 29 1983 125 PM  |  |  |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>Caucasian   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>3 24 1930  |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS.<br>53   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Illinois  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>United States  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.  |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Homemaker   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE<br>Maryland   |  |  |  | 13b. COUNTY<br>Montgomery   |  | 13c. CITY OR TOWN<br>Bethesda  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                                       |  |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Carl Popp   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Adeline Rode  |  | 13e. STREET ADDRESS<br>7815 English Way (20817)  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>336-26-5027  |  | 17. INFORMANT ADDRESS<br>Dr. Walton A. Rodger, same as #13  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>5715 IMMEDIATE CAUSE (a) Gastrointestinal Hemorrhage<br>DUE TO, OR AS A CONSEQUENCE OF (b) CIRRHOSIS, MICRONODULAR, SEVERE<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 DAYS<br>INDETERMINATE |  |  |  |   |  |  |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16<br>HEPATO RENAL FAILURE, ASCITES   |  |  |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>NO   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/17/83, 1983, to 4/29/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>Gary M. Roggin M.D.  |  |  |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/29/83  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>GARY M. ROGGIN M.D.   |  |  |  | 22e. ADDRESS<br>10215 FORNWOOD RD. BETHESDA MD  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |  | 23b. DATE<br>May 9 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Glen Oak Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Hillside, Illinois  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME<br>Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland 20814   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 10 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine   |  |  |  |  |  |

BP

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CHIEF

200% COTTON





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 6 6

REG. NO.

1- STATE  
REGISTRAR

|   |   |   |   |   |  |
|---|---|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Arthur BERTRUM Rosenblatt  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>4-22-83                                     |   | 2b. HOUR<br>5 P.M.   |
| 3. SEX<br>Male  | 4. RACE<br>WHITE  | 5. DATE OF BIRTH MONTH DAY YEAR<br>2-14-31  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS.                                      |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>DC   | 7b. CITIZEN OF WHAT COUNTRY?<br>U. S. A.  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                          |   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hosp |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Postal Service |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. Govt.  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Maryland  |   | 13b. COUNTY<br>Montgomery   | 13c. CITY OR TOWN<br>Silver Spring  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Abraham Aaron Rosenblatt   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Jedn Kaplan   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>yes  |   | 16b. SOCIAL SECURITY NO.<br>577-42-2171   | 17. INFORMANT ADDRESS<br>Geraldine M. Rosenblatt Same as No. 13                 |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1889 Gas TRD in Toilet Room Apartment<br>(b) Adenocarcinoma of Bladder<br>(c) DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |   |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 Hr.<br>6 mos.  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |   |   |   |   |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/14 1983 to 4/22 1983 that (I) (we) lost saw the deceased alive on 4/22 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |   |   |   |   |  |
| 22b. SIGNATURE<br>M.D. H. LEVIA   |   | DEGREE<br>M.D.  |   | 22c. DATE SIGNED<br>4/22/83   |  |
| 22d. PHYSICIAN'S NAME<br>H. LEVIA   |   | 22e. ADDRESS<br>8630 FEATHERWOOD Silver Spring, Md.   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   | 23b. DATE<br>4/24/1983  | 23c. NAME OF CEMETERY OR CREMATORY<br>Judean Memorial Gardens   |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Olney, Montgomery, Maryland                          |  |
| 24. FUNERAL DIRECTOR<br>Donald M. Stein   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 27 1983  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Smith   |  |
| 232 Carroll Street, N. W. Washington, D. C.   |   |   |   |   |  |





CHIEF IN CHARGE

20% COTTON



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal of the body. Page 1 should be retained by the funeral director. IMPORTANT: If item 21 is marked or item 78 shows any injury, or other traumatic event, the death certificate must be completed at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |   |   |  |  |  |   |                           |  |  |
|---|--|--|---|---|--|--|--|---|---------------------------|--|--|
| 1. FOR STATE REGISTRAR  |  | REG. NO.   |   | 8311067   |  |  |  |   |                           |  |  |
| 1 DECEASED NAME (TYPE OR PRINT)   |  |  | 2a DATE OF DEATH  |   |  | 2b HOUR  |  |   |                           |  |  |
| EVA GOLDBERG ROZYCKI  |  |  | APRIL 13 1983   |   |  | 4:30 P.M.  |  |   |                           |  |  |
| 3 SEX   |  | 4 RACE   |   | 5 DATE OF BIRTH   |  | 6 AGE (IN YEARS LAST BIRTHDAY)   |  | 7 UNDER 1 YEAR  |                           | 7 UNDER 24 HRS                               |  |
| FEMALE  |  | WHITE  |   | DECEMBER 6, 1910  |  | 72 YRS.  |  | MONTHS DAYS   |                           | HOURS MIN                                    |  |
| 7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7c CITIZEN OF WHAT COUNTRY?  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH  |  |   |                           |  |  |
| CONNECTICUT   |  | U.S.A.   |   |   |  | MONTGOMERY COUNTY MD.  |  |   |                           |  |  |
| 10 CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |   |   |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b KIND OF BUSINESS OR INDUSTRY                              |                           |  |  |
| SILVER SPRING   |  | CARRIAGE HILL NURSING & RECREATION CENTER  |   |   |  | HOUSEWIFE  |  | OWN HOME  |                           |  |  |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  | 13b INSIDE CITY LIMITS?   |   |  | 13c STREET ADDRESS   |  |   |                           |  |  |
| 13a STATE MARYLAND  |  |  | 13b YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  | 2445 LYTTONSVILLE ROAD 20910   |  |   |                           |  |  |
| 14 FATHER'S NAME  |  |  | 15 MOTHER'S MAIDEN NAME   |   |  |  |  |   |                           |  |  |
| HYMAN GOLDBERG  |  |  | CELIA WEINER  |   |  |  |  |   |                           |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  | 16b SOCIAL SECURITY NO.   |   |  | 17 INFORMANT   |  |   |                           |  |  |
| NO  |  |  | 579-32-0106   |   |  | 2445 LYTTONSVILLE ROAD<br>ELI ROZYCKI, SILVER SPRING, MARYLAND   |  |   |                           |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |  |   |   |  |  |  |   |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART I. DEATH WAS CAUSED BY:  |  |  |   |   |  |  |  |   |                           |  |  |
| IMMEDIATE CAUSE (a) 4039  |  |  |   |   |  |  |  |   |                           | 1 year                                       |  |
| DUE TO, OR AS A CONSEQUENCE OF (b) Hypertensive muscular disease  |  |  |   |   |  |  |  |   |                           | 5 years                                      |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |   |   |  |  |  |   |                           |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)   |  |  |   |   |  |  |  |   |                           |  |  |
| Day was cause undetermined  |  |  |   |   |  |  |  |   |                           |  |  |
| 19a DATE OF OPERATION   |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                         |   |  | 20a AUTOPSY?   |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                           |  |  |
|   |  |  |   |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>      |                           |  |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b TIME OF INJURY  |   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |                           |  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR  |   |  |  |  |   |                           |  |  |
|   |  |  | P.M. 19   |   |  |  |  |   |                           |  |  |
| 21d INJURY OCCURRED   |  |  | 21e PLACE OF INJURY   |   |  | 21f LOCATION   |  |   | 21g CITY OR TOWN          |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                          |   |  | STREET   |  |   | COUNTY STATE              |  |  |
| 22a I certify that (I) (this hospital) attended the deceased from June 19, 1982 to April 13, 1983, that (I) (we) last saw the deceased alive on March 26, 1983 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |   |   |  |  |  |   |                           |  |  |
| 22b SIGNATURE   |  |  | DEGREE  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   | 22c DATE SIGNED           |  |  |
| BLAINE H. EIG   |  |  | M.D.  |   |  |  |  |   | April 13, 1983            |  |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  | 22e ADDRESS   |   |  | 22f LOCATION   |  |   |                           |  |  |
|   |  |  | 9801 GEORGIA AVE SILVER SPRING MD                                       |   |  | CITY OR TOWN COUNTY STATE  |  |   |                           |  |  |
| 23a BURIAL, CREMATION, REMOVAL  |  |  | 23b DATE  |   |  | 23c NAME OF CEMETERY OR CREMATORY  |  |   | 23d LOCATION              |  |  |
| BURIAL  |  |  | 4/15/1983   |   |  | BETH EL MEMORIAL PARK  |  |   | HAMDEN CONNECTICUT        |  |  |
| 24 FUNERAL DIRECTOR   |  |  |   |   |  | 25a DATE REC'D. BY REGISTRAR   |  |   | 25b REGISTRAR'S SIGNATURE |  |  |
| DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME  |  |  |   |   |  | APR 19 1983  |  |   | John J. Connel            |  |  |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C.  |  |  |   |   |  |  |  |   |                           |  |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 6 8

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |   |   |   |  |   |  |  |  |
|---|--|---|---|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HETEN D. Russ</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 17 83</b> |   |  | 2b. HOUR<br><b>4:20 PM</b>  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>Caucasian</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Aug. 19, 1918</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>64</b>  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>17</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>West Virginia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At Home</b>  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |   | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>1914 Lewis Avenue</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Howard W. Whithair</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Daisy Unknown</b>   |  |   |  | 16. ADDRESS<br><b>1014 Sunnybrook Dr.,<br/>Glen Burnie, Md. 21061</b>  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>None</b>  |   | 17. INFORMANT<br><b>Donald Miller, Son</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Chronic Obstructive Pulmonary Emphysema</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 weeks</b><br><b>10 years</b> |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |  |   |   |   |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>809 Viers Mill Rd. Rockville, Md 20851</b>  |  |   |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>4/11/83</b> to <b>4/17/83</b> , that (I) (we) last saw the deceased alive on <b>4/17/83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |   |   |   |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Robert C. Macon</b>  |  |   |   | 22c. DEGREE<br><b>M.D.</b>  |  |   |  | 22d. DATE SIGNED<br><b>4/17/83</b>   |  |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Robert C. Macon</b>   |  |   |   | 22f. ADDRESS<br><b>809 Viers Mill Rd. Rockville, Md 20851</b>   |  |   |  |  |  |
| 23a. BURIAL, CREMATION, OR OTHER DISPOSITION (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Apr. 21, 1983</b>   |   | 23c. NAME OF CEMETERY OR REPOSITORY<br><b>Arlington National</b>  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington, Virginia</b>  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>W.W. CHAMBERS CO., 8655 Ga. Ave. SS, Md. 20914</b>   |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 21 1983</b>   |  |   |  |  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |  |   |  |  |  |



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 6 9

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |   |   |  |  |  |   |  |
|---|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>RUTH BERNICE ROSS</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 17 1983</b> |   |  | 2b. HOUR<br>P M<br><b>3:16 P M</b>   |  |   |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>MARCH 1 1913</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.<br><b>YRS.</b> |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>NEW JERSEY</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>UNITED STATES</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                        |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>BETHESDA</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>NAVAL HOSPITAL</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>RETIRED</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>U.S.A.F.</b>        |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13b. STATE<br><b>DISTRICT OF COLUMBIA</b> |  |  |   | 13c. CITY OR TOWN<br><b>COLUMBIA</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HERMAN ROSS</b>  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>LOUISE GUENZBURG</b>  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>YES</b>  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE YEAR OR DATES)<br><b>1951-1973</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>LEON I. ROSS, P.O. Box 514 Grand Cayman, BWI</b>   |  |  |  |   |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a) **ATHROSCLEROTIC CORONARY ARTERY DISEASE AND AORTIC STENOSIS**

4140

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| 19a. DATE OF OPERATION<br><b>13 April 1983</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>AORTIC STENOSIS &amp; CAD</b> |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                    |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)               |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>APRIL 5</b> , 19 <b>83</b> , to <b>APRIL 17</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>APRIL 17</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above. (I) (we) (did) (did) not view the body after death. |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><i>R. Peniston</i>  |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>19 April 83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>R. PENISTON, CDR, MC, USNR</b>  |  |  |  | 22e. ADDRESS<br><b>NAVAL HOSPITAL, NAVAL MEDICAL<br/>COMMAND, NATIONAL CAPITAL REGION, BETHESDA,</b>                                       |  |  |  |

|  |  |                                   |  |  |  |  |  |
|--|--|-----------------------------------|--|--|--|--|--|
| 23a. BURIAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>Apr. 20, 1983</b> |  | 23c. NAME OF CEMETERY<br><b>Arlington National</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington MD 20814 Virginia</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>W. W. CHAMBERS CO., 8655 Ga. Ave. SS. Md. 20910</b> |  |                                   |  | 25a. DATE RECD. BY REGISTRAR<br><b>APR 21 1983</b> |  |  |  |

THE WHITE HOUSE



DEPARTMENT OF THE INTERIOR

UNITED STATES OF AMERICA

WASHINGTON, D. C.

OFFICE OF THE SECRETARY

1900

1900

*[Handwritten signature]*

RECEIVED

*[Handwritten signature]*

1900



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME  
(TYPE OR PRINT)

FIRST MIDDLE LAST  
WINDSON Thomas Russell

2b. DATE KNOWN OF DEATH ☒ ESTIMATED ☐ MATED ☐  
MONTH DAY YEAR  
4-2 83  
19  
2b. HOUR 11:30 P.M.

3. SEX

M

4. RACE

B.

5. DATE OF BIRTH

MONTH DAY YEAR  
11 5 15

6. AGE (IN YEARS)

67

IF UNDER 1 YR.

MONTHS

DAYS

HOURS

MIN.

IF UNDER 24 HRS.

7c. DATE PRONOUNCED DEAD

MONTH DAY YEAR  
4-2 83  
19

2d. HOUR 11:30 P.M.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

Md.

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

MD

10. CITY OR TOWN OF DEATH

Gaithersburg

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION

9901 Spiceberry Circle

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

Laborer

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

Md.

13b. COUNTY

Montg.

13c. CITY OR TOWN

Gaithersburg

13d. INSIDE CITY LIMITS?

YES ☐ NO ☐

13e. STREET ADDRESS

9901 Spiceberry Circle # A

14. FATHER'S NAME

FIRST MIDDLE LAST

Perry T. Russell

15. MOTHER'S MAIDEN NAME

FIRST MIDDLE LAST

Margaret Campbell

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.

214-18-8047

17. INFORMANT

ADDRESS

Gladys Russell (wife)

SAME AS #13

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY:

4100

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M. MONTH DAY YEAR

P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐AT WORK ☐ AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that I took charge of the remains described above, held an

Autopsy ☐Inspection ☒Inquiry ☐

and in my opinion

death resulted from: Natural causes ☒Accident ☐Suicide ☐Homicide ☐Undetermined manner ☐

ACTUAL SIGNATURE

*John Tauber*

M.D.

MEDICAL EXAMINER

DATE SIGNED

4-2-83

EXAMINER'S NAME

(TYPE OR PRINT)

John Tauber

ADDRESS

821 Wisconsin Ave.

23a. BURIAL, CREMATION, REMOVAL

Burial

23b. DATE

4-8-83

23c. NAME OF CEMETERY OR CREMATORY

Brooke Grove Cem.

23d. LOCATION

CITY OR TOWN

Laytonsville

COUNTY

Montg.

STATE

24. FUNERAL DIRECTOR

NAME

George R. Snowden

ADDRESS

246 N. WASH. ST.

Rockville, Md.

25a. DATE REC'D. BY REGISTRAR

APR 7 1983

25b. REGISTRAR'S SIGNATURE

*John Tauber*

*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page. The text is mostly obscured by noise and artifacts.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  |   |  |  |   |  |  | 8311071 |
|---|--|--|--|---|--|--|---|--|--|---------|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.   |  |   |  |  |         |
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Julia Cecilia RYAN</i>   |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <i>4/14/1983</i>                                 |  |   | 2b. HOUR<br>MIN. <i>530/P</i>  |  |         |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>Caucasian</i>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR <i>04 03 1903</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>80</i> YRS.  |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |  |         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Ireland</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>MONTGOMERY</i> MD.  |   |  |  |         |
| 10. CITY OR TOWN OF DEATH<br><i>WHEATON</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>University Hsg. Home</i> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>SEAMRESS</i>  |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |         |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)   |  |  |  |   | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><i>308 Haddon Dr. 20912</i>                            |  |  |         |
| 13a. STATE<br><i>Maryland</i>   |  | 13b. COUNTY<br><i>Pr. Geo.</i>   |  | 13c. CITY OR TOWN<br><i>Takoma Park</i>   |  |  |   |  |  |         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Richard Hamilton Kenna</i>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Julia Kenna</i>   |  |  |   |  |  |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><i>NO</i>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><i>082-07-2727</i>  |  | 17. INFORMANT<br><i>Daughter</i> ADDRESS<br><i>Julia T. Ryan, C.N.D. Same as 13</i>  |   |  |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><i>4960</i> IMMEDIATE CAUSE (a) <i>Massive recurrent stroke</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <i>Pneumonia</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <i></i>                                  |  |  |  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>1 wk</i><br><i>1 wk</i>   |  |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |   |  |  |         |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |  |         |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |   |  |  |         |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>Jan 1980</i> to <i>4/14/83</i> , that (I) (we) lost saw the deceased alive on <i>4/14/83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  |  |  |   |  |  |   |  |  |         |
| 22b. SIGNATURE<br><i>Smith S. Ho</i>  |  |  |  |   |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED   |  |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>SMITH S. Ho, M.D.</i>   |  |  |  |   |  | 22e. ADDRESS<br><i>8323 Haddon Dr Takoma #1 md</i>   |   |  |  |         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><i>Burial</i>   |  |  | 23b. DATE<br><i>Apr. 19, 1983</i>                                      |   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Mt. St. Marys</i>                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Flushing Queens New York</i> |  |  |         |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><i>Francis J. Collins 500 University Blvd., W. Silver Spring, Md.</i>   |  |  |  |   |  | 25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE<br><i>APR 21 1983 [Signature]</i>   |   |  |  |         |



APR 21 1983

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE   |  |  |  | 8 3 1 1 0 7 2  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |
| FIRST MIDDLE LAST<br><i>Ruth A RYAN</i>  |  |  |  | 4-7-83 3 <sup>20</sup> P M   |  |
| 3 SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  |
| Female   |  | White  |  | Feb. 5, 1906   |  |
| 6a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Washington, D.C.   |  | USA  |  | 77 YRS.  |  |
| 10 CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| Takoma Park  |  | Washington Adventist Hospital  |  | Montgomery MD.   |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  | 13a. STREET ADDRESS  |  |
| Sect.  |  | Self Employed  |  | 9130 Bridgewater St. 20740   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13d. INSIDE CITY LIMITS?   |  |
| Maryland   |  | Prince Georges College Pk.   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |
| Clarence Ray McClelland  |  | Kate Lorena Kuehling   |  | N/A  |  |
| 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Small cell bronchogenic carcinoma</i> |  |
| 213-38-4572  |  | Patricia R. Carson-daughter- (same as 13e)   |  | 1629 } DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>COPD, Atrial Fibrillation Probable Secund ACTH + MSH 2° cancer.</i>  |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> 19 <i>82</i> , to <i>7 Am</i> 19 <i>83</i> , that (I) <del>found</del> lost saw the deceased alive on <i>6 Am</i> 19 <i>83</i> , and that in (my) <del>four</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>will</del> <i>did not</i> view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| <i>Donald E. Dillon M.D.</i>   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 7 Am 83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |
| Donald E. Dillon, M.D.   |  | 1811 Pr. Philip Dr. Chevy Md.  |  | Burial   |  |
| 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE  |  |
| 4-9-1983   |  | Fort Lincoln Cemetery  |  | Brentwood Pr. Georges Md.  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE   |  |
| Hines/Rinaldi Funeral Home   |  | 11800 N.H. Ave., S.S. Md. 20904  |  | APR 11 1983 <i>John J. Carver</i>  |  |

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

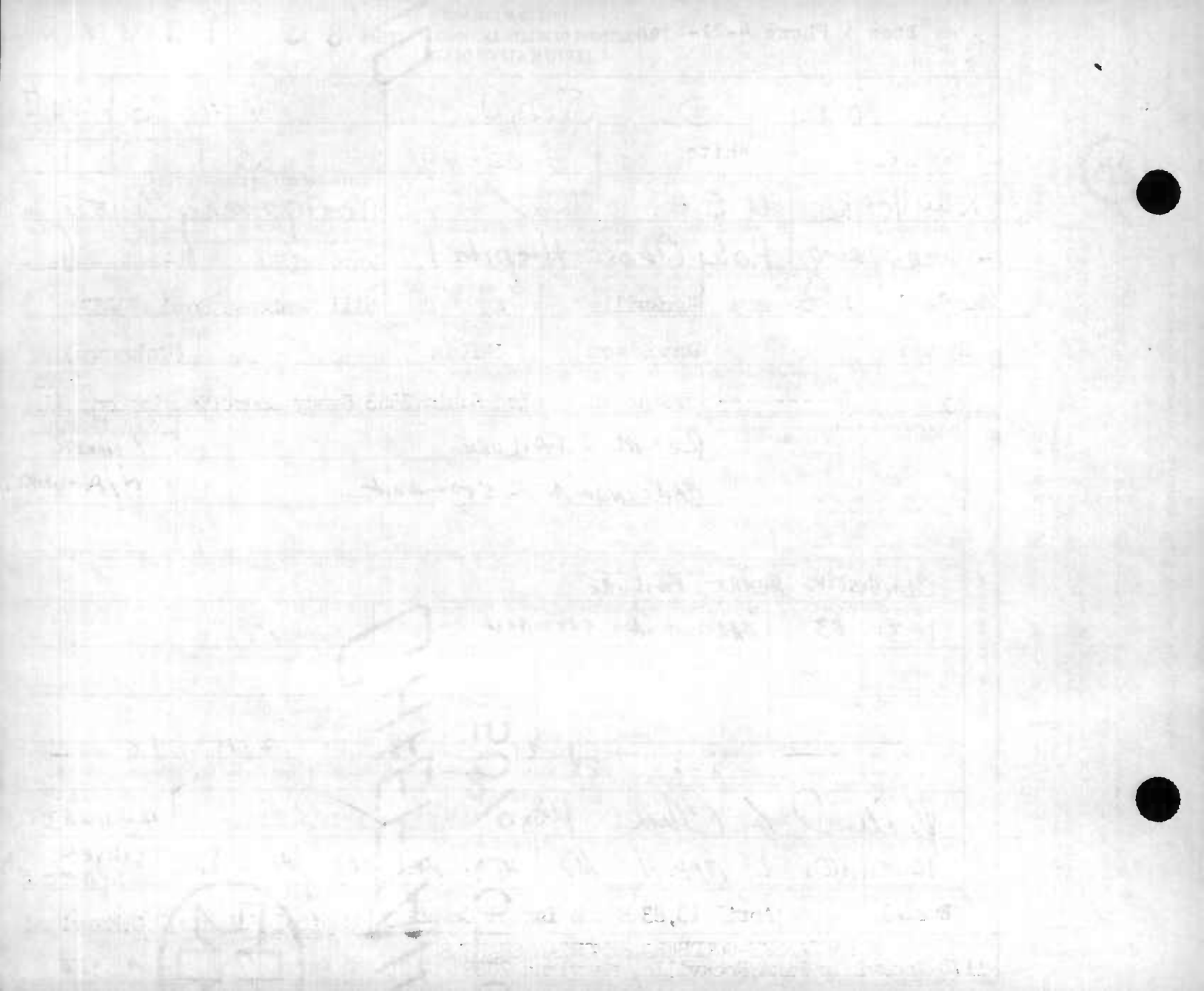
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| FOR Item 4 Phone 4-21-83   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 3 1 1 0 7 3   |  |  |  |
|--|--|--|--|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH   |  |  |  | 2b. HOUR  |  |  |  |
| 3. SEX   |  |  |  | 4. RACE   |  |  |  | 5. DATE OF BIRTH  |  |  |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)  |  |  |  | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  |  |  | 7b. CITIZEN OF WHAT COUNTRY?  |  |  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |  |  | 10. CITY OR TOWN OF DEATH   |  |  |  |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT INCH FACILITY GIVE STREET ADDRESS)   |  |  |  | 12a. USUAL OCCUPATION   |  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |
| 13a. STATE   |  |  |  | 13b. COUNTY   |  |  |  | 13c. CITY OR TOWN   |  |  |  |
| 14. FATHER'S NAME  |  |  |  | 15. MOTHER'S MAIDEN NAME  |  |  |  | 16. SOCIAL SECURITY NO.   |  |  |  |
| 17. INFORMANT  |  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |  |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?   |  |  |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?   |  |  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY   |  |  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)   |  |  |  | 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY  |  |  |  |
| 21f. LOCATION  |  |  |  | 21g. COUNTY   |  |  |  | 21h. STATE  |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from  |  |  |  | 22b. DATE SIGNED  |  |  |  | 22c. DATE SIGNED  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  | 22e. ADDRESS  |  |  |  | 22f. DATE SIGNED  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  |  | 23b. DATE   |  |  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  |
| 23d. LOCATION  |  |  |  | 23e. CITY OR TOWN   |  |  |  | 23f. COUNTY   |  |  |  |
| 23g. STATE   |  |  |  | 23h. DATE REC'D. BY REGISTRAR   |  |  |  | 23i. REGISTRAR'S SIGNATURE  |  |  |  |
| 24. FUNERAL DIRECTOR   |  |  |  | 24a. DATE REC'D. BY REGISTRAR   |  |  |  | 24b. REGISTRAR'S SIGNATURE  |  |  |  |
| Ray D Sabin  |  |  |  | 4-11-83   |  |  |  | 2:00 PM   |  |  |  |
| Female   |  |  |  | White   |  |  |  | 9-03-99   |  |  |  |
| 83 YRS   |  |  |  | New York  |  |  |  | U.S.A.  |  |  |  |
| MONTGOMERY COUNTY  |  |  |  | MONTGOMERY COUNTY   |  |  |  | MONTGOMERY COUNTY   |  |  |  |
| Silver Spring  |  |  |  | Holy Cross Hospital   |  |  |  | Housewife   |  |  |  |
| Maryland   |  |  |  | Montgomery  |  |  |  | Rockville   |  |  |  |
| Hyman  |  |  |  | Davidson  |  |  |  | Hulda   |  |  |  |
| (Unknown)  |  |  |  | 20795   |  |  |  | Ira Sabin; 3503 Sandy Court; Kensington, Md.                        |  |  |  |
| NO   |  |  |  | 578-48-2209   |  |  |  | 1519  |  |  |  |
| RENN FAILURE   |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  | N/A - UNK.  |  |  |  |
| CALCINOMA - STOMACH  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF  |  |  |  |   |  |  |  |
| CONGESTIVE HEART FAILURE   |  |  |  |   |  |  |  |   |  |  |  |
| 1-31-83  |  |  |  | CALCINOMA - STOMACH   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21b. TIME OF INJURY  |  |  |  | 21c. HOW INJURY OCCURRED  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21d. INJURY OCCURRED   |  |  |  | 21e. PLACE OF INJURY  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21f. LOCATION  |  |  |  | 21g. COUNTY   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21h. STATE   |  |  |  | 21i. DATE SIGNED  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21j. DATE SIGNED   |  |  |  | 21k. DATE SIGNED  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21l. DATE SIGNED   |  |  |  | 21m. DATE SIGNED  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21n. DATE SIGNED   |  |  |  | 21o. DATE SIGNED  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21p. DATE SIGNED   |  |  |  | 21q. DATE SIGNED  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21r. DATE SIGNED   |  |  |  | 21s. DATE SIGNED  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21t. DATE SIGNED   |  |  |  | 21u. DATE SIGNED  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21v. DATE SIGNED   |  |  |  | 21w. DATE SIGNED  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21x. DATE SIGNED   |  |  |  | 21y. DATE SIGNED  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21z. DATE SIGNED   |  |  |  | 21aa. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ab. DATE SIGNED  |  |  |  | 21ac. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ad. DATE SIGNED  |  |  |  | 21ae. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21af. DATE SIGNED  |  |  |  | 21ag. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ah. DATE SIGNED  |  |  |  | 21ai. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21aj. DATE SIGNED  |  |  |  | 21ak. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21al. DATE SIGNED  |  |  |  | 21am. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21an. DATE SIGNED  |  |  |  | 21ao. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ap. DATE SIGNED  |  |  |  | 21aq. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ar. DATE SIGNED  |  |  |  | 21as. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21at. DATE SIGNED  |  |  |  | 21au. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21av. DATE SIGNED  |  |  |  | 21aw. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ax. DATE SIGNED  |  |  |  | 21ay. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21az. DATE SIGNED  |  |  |  | 21ba. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ba. DATE SIGNED  |  |  |  | 21bb. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bb. DATE SIGNED  |  |  |  | 21bc. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bc. DATE SIGNED  |  |  |  | 21bd. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bd. DATE SIGNED  |  |  |  | 21be. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21be. DATE SIGNED  |  |  |  | 21bf. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bf. DATE SIGNED  |  |  |  | 21bg. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bg. DATE SIGNED  |  |  |  | 21bh. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bh. DATE SIGNED  |  |  |  | 21bi. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bi. DATE SIGNED  |  |  |  | 21bj. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bj. DATE SIGNED  |  |  |  | 21bk. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bk. DATE SIGNED  |  |  |  | 21bl. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bl. DATE SIGNED  |  |  |  | 21bm. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bm. DATE SIGNED  |  |  |  | 21bn. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bn. DATE SIGNED  |  |  |  | 21bo. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bo. DATE SIGNED  |  |  |  | 21bp. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bp. DATE SIGNED  |  |  |  | 21bq. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bq. DATE SIGNED  |  |  |  | 21br. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21br. DATE SIGNED  |  |  |  | 21bs. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bs. DATE SIGNED  |  |  |  | 21bt. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bt. DATE SIGNED  |  |  |  | 21bu. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bu. DATE SIGNED  |  |  |  | 21bv. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bv. DATE SIGNED  |  |  |  | 21bw. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bw. DATE SIGNED  |  |  |  | 21bx. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bx. DATE SIGNED  |  |  |  | 21by. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21by. DATE SIGNED  |  |  |  | 21bz. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21bz. DATE SIGNED  |  |  |  | 21ca. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ca. DATE SIGNED  |  |  |  | 21cb. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cb. DATE SIGNED  |  |  |  | 21cc. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cc. DATE SIGNED  |  |  |  | 21cd. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cd. DATE SIGNED  |  |  |  | 21ce. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ce. DATE SIGNED  |  |  |  | 21cf. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cf. DATE SIGNED  |  |  |  | 21cg. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cg. DATE SIGNED  |  |  |  | 21ch. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ch. DATE SIGNED  |  |  |  | 21ci. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ci. DATE SIGNED  |  |  |  | 21cj. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cj. DATE SIGNED  |  |  |  | 21ck. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ck. DATE SIGNED  |  |  |  | 21cl. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cl. DATE SIGNED  |  |  |  | 21cm. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cm. DATE SIGNED  |  |  |  | 21cn. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cn. DATE SIGNED  |  |  |  | 21co. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21co. DATE SIGNED  |  |  |  | 21cp. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cp. DATE SIGNED  |  |  |  | 21cq. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cq. DATE SIGNED  |  |  |  | 21cr. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cr. DATE SIGNED  |  |  |  | 21cs. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cs. DATE SIGNED  |  |  |  | 21ct. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ct. DATE SIGNED  |  |  |  | 21cu. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cu. DATE SIGNED  |  |  |  | 21cv. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cv. DATE SIGNED  |  |  |  | 21cw. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cw. DATE SIGNED  |  |  |  | 21cx. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cx. DATE SIGNED  |  |  |  | 21cy. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cy. DATE SIGNED  |  |  |  | 21cz. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21cz. DATE SIGNED  |  |  |  | 21da. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21da. DATE SIGNED  |  |  |  | 21db. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21db. DATE SIGNED  |  |  |  | 21dc. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dc. DATE SIGNED  |  |  |  | 21dd. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dd. DATE SIGNED  |  |  |  | 21de. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21de. DATE SIGNED  |  |  |  | 21df. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21df. DATE SIGNED  |  |  |  | 21dg. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dg. DATE SIGNED  |  |  |  | 21dh. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dh. DATE SIGNED  |  |  |  | 21di. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21di. DATE SIGNED  |  |  |  | 21dj. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dj. DATE SIGNED  |  |  |  | 21dk. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dk. DATE SIGNED  |  |  |  | 21dl. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dl. DATE SIGNED  |  |  |  | 21dm. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dm. DATE SIGNED  |  |  |  | 21dn. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dn. DATE SIGNED  |  |  |  | 21do. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21do. DATE SIGNED  |  |  |  | 21dp. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dp. DATE SIGNED  |  |  |  | 21dq. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dq. DATE SIGNED  |  |  |  | 21dr. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dr. DATE SIGNED  |  |  |  | 21ds. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ds. DATE SIGNED  |  |  |  | 21dt. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dt. DATE SIGNED  |  |  |  | 21du. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21du. DATE SIGNED  |  |  |  | 21dv. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dv. DATE SIGNED  |  |  |  | 21dw. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dw. DATE SIGNED  |  |  |  | 21dx. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dx. DATE SIGNED  |  |  |  | 21dy. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dy. DATE SIGNED  |  |  |  | 21dz. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21dz. DATE SIGNED  |  |  |  | 21ea. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ea. DATE SIGNED  |  |  |  | 21eb. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21eb. DATE SIGNED  |  |  |  | 21ec. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ec. DATE SIGNED  |  |  |  | 21ed. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ed. DATE SIGNED  |  |  |  | 21ee. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ee. DATE SIGNED  |  |  |  | 21ef. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ef. DATE SIGNED  |  |  |  | 21eg. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21eg. DATE SIGNED  |  |  |  | 21eh. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21eh. DATE SIGNED  |  |  |  | 21ei. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ei. DATE SIGNED  |  |  |  | 21ej. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ej. DATE SIGNED  |  |  |  | 21ek. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ek. DATE SIGNED  |  |  |  | 21el. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21el. DATE SIGNED  |  |  |  | 21em. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21em. DATE SIGNED  |  |  |  | 21en. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21en. DATE SIGNED  |  |  |  | 21eo. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21eo. DATE SIGNED  |  |  |  | 21ep. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ep. DATE SIGNED  |  |  |  | 21eq. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21eq. DATE SIGNED  |  |  |  | 21er. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21er. DATE SIGNED  |  |  |  | 21es. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21es. DATE SIGNED  |  |  |  | 21et. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21et. DATE SIGNED  |  |  |  | 21eu. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21eu. DATE SIGNED  |  |  |  | 21ev. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ev. DATE SIGNED  |  |  |  | 21ew. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ew. DATE SIGNED  |  |  |  | 21ex. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ex. DATE SIGNED  |  |  |  | 21ey. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ey. DATE SIGNED  |  |  |  | 21ez. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ez. DATE SIGNED  |  |  |  | 21fa. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fa. DATE SIGNED  |  |  |  | 21fb. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fb. DATE SIGNED  |  |  |  | 21fc. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fc. DATE SIGNED  |  |  |  | 21fd. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fd. DATE SIGNED  |  |  |  | 21fe. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fe. DATE SIGNED  |  |  |  | 21ff. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ff. DATE SIGNED  |  |  |  | 21fg. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fg. DATE SIGNED  |  |  |  | 21fh. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fh. DATE SIGNED  |  |  |  | 21fi. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fi. DATE SIGNED  |  |  |  | 21fj. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fj. DATE SIGNED  |  |  |  | 21fk. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fk. DATE SIGNED  |  |  |  | 21fl. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fl. DATE SIGNED  |  |  |  | 21fm. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fm. DATE SIGNED  |  |  |  | 21fn. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fn. DATE SIGNED  |  |  |  | 21fo. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fo. DATE SIGNED  |  |  |  | 21fp. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fp. DATE SIGNED  |  |  |  | 21fq. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fq. DATE SIGNED  |  |  |  | 21fr. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fr. DATE SIGNED  |  |  |  | 21fs. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fs. DATE SIGNED  |  |  |  | 21ft. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ft. DATE SIGNED  |  |  |  | 21fu. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fu. DATE SIGNED  |  |  |  | 21fv. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fv. DATE SIGNED  |  |  |  | 21fw. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fw. DATE SIGNED  |  |  |  | 21fx. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fx. DATE SIGNED  |  |  |  | 21fy. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fy. DATE SIGNED  |  |  |  | 21fz. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21fz. DATE SIGNED  |  |  |  | 21ga. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21ga. DATE SIGNED  |  |  |  | 21gb. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21gb. DATE SIGNED  |  |  |  | 21gc. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21gc. DATE SIGNED  |  |  |  | 21gd. DATE SIGNED   |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
|  |  |  |  |   |  |  |  |   |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon-pages 1 and 2 and should be filed in the office 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   |   | 8 3 1 1 0 7 4   |  |
|---|--|--|---|---|---|--|
| FOR<br>1 - STATE REGISTRAR  |  |  | REG. NO.  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>RHODA A. SANDISON   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 6 1983         |   | 2b. HOUR<br>11:07AM   |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>MAY 30, 1904  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>78 YRS  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>HUNGARY  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.   |
| 10. CITY OR TOWN OF DEATH<br>SILVER SPRING  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>10,000 BRUNSWICK AVENUE |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>FINANCIAL MANAGER   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>STOCK MARKET  |
| 13a. STATE<br>MARYLAND  |  |  | 13b. COUNTY<br>MONTGOMERY                                   |   | 13c. CITY OR TOWN<br>SILVER SPRING  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ISADORE ABRAMOWITZ  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>LENA JAFFE |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>086-03-4188                     |   | 17. INFORMANT<br>NEPHEW ADDRESS<br>KENNETH ALLEN ELSNER 3003 PARKER AVENUE WHEATON, MD. 20902 |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1: DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>arrhythmia</u><br>3989 DUE TO, OR AS A CONSEQUENCE OF <u>Heart disease</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <u>Renal failure &amp; arteriosclerosis</u><br>DUE TO, OR AS A CONSEQUENCE OF <u>Renal failure</u><br>(c) <u>Renal failure</u> |  |  |   |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>acute</u><br><u>yes</u><br><u>yes</u>                                   |
| PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>hypertension, renal failure</u>  |  |  |   |   |   |  |
| 19a. DATE OF OPERATION<br><u>1983</u>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>renal failure</u>   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1983</u> to <u>Apr 6</u> 19 <u>83</u> , that (I) <del>was</del> lost<br>saw the deceased alive on <u>MAR 31</u> 19 <u>83</u> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated<br>above (I) <del>did</del> (did not) view the body after death.   |  |  |   |   |   |  |
| 22b. SIGNATURE<br><u>John S. AIA</u>  |  | DEGREE<br><u>MD</u>  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |   | 22c. DATE SIGNED<br><u>4/6/83</u>  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><u>John S. AIA</u>   |  | 22e. ADDRESS<br><u>809 Uiers Mill Rd</u>   |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION   |  | 23b. DATE<br>4/7/83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>METROPOLITAN CREMATORY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>ALEXANDRIA VIRGINIA  |
| 24. FUNERAL DIRECTOR<br>NAME<br>FRANCIS J. COLLINS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 14 1983  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carney</u>  |

BP

James H. Smith

James H. Smith

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 7 5

FOR  
1. STATE  
REGISTRAR

REG. NO.

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HOWARD H SANDY</b>                       |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR <b>4-16-83</b>  |  | 2b. HOUR<br><b>2:28 M</b>  |
| 3. SEX<br><b>male</b>   | 4. RACE<br><b>W</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR <b>01-30-96</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>87</b> YRS.                    | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kentucky</b>                    | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.        |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>                               | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Farmer</b>               | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Farming</b>                  |  |
| 13a. STATE<br><b>Penn.</b>  | 13b. COUNTY<br><b>Crawford</b>  | 13c. CITY OR TOWN<br><b>Conneaut Lake</b>   | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET ADDRESS<br><b>RD #2</b>                                  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Sandy</b>                  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>(unobtainable)</b>                          |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>Yes</b> |   | 16b. SOCIAL SECURITY NO.<br><b>WWII 189 14 8257</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Margaret Sandy (Wife) Same as 13e</b> |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

4100 IMMEDIATE CAUSE (a) **acute myocardial infarction**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **coronary atherosclerosis**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH**8 hours**

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |  |
|--|--|--|--|
| 19a. DATE OF OPERATION   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4-15</b> 19 <b>83</b> , to <b>4-16</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>4-15</b> 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) did not view the body after death. |  |  |  |
| 22b. SIGNATURE<br><b>Mark S. Rosen</b>   | DEGREE<br><b>MD</b>  |  | 22c. DATE SIGNED<br><b>4/16/83</b>   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Mark Rosen</b>   | 22e. ADDRESS<br><b>1131 Univ. Blvd. W.<br/>Silver Spring, Md.</b>      |  |  |

MEDICAL CERTIFICATION

1

|   |                             |   |   |
|---|-----------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>     | 23b. DATE<br><b>4/20/83</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Evergreen Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Harmonsburg Crawford Pa.</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Hines/Rinaldi Funeral Home</b> |                             | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 19 1983</b>             |   |
| ADDRESS<br><b>11800 New Hamp. Ave.</b>                            |                             | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Chief</b>              |   |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

100

CHIEF

2000 COLL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |   |  |   | REG. NO.                                     |                     |                                  |  |
|---|--|--|--|--|--|---|---|--|---|--|---------------------|----------------------------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |  | 8 3 1 1 0 7 6  |   |   |  |   |  |                     |                                  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  |  | 2a. DATE OF DEATH  |   |   |  |   | 2b. HOUR                                     |                     |                                  |  |
| FIRST MIDDLE LAST<br>CARL SAVITSKY  |  |  |  |  | MONTH DAY YEAR<br>4/ 27/ 83  |   |   |  |   | 1:35 P M                                     |                     |                                  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                               |   | 7. UNDER 1 YEAR  |   | 7. UNDER 24 HRS                              |                     |                                  |  |
| MALE  |  | WHITE  |  | MONTH DAY YEAR<br>DEC 10 1918  |  | 64 YRS.   |   | MONTHS DAYS  |   | HOURS MIN.                                   |                     |                                  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                          |   |  |   |  |                     |                                  |  |
| MASS.   |  | U.S.A.   |  |  |  | MONTGOMARY County MD.   |   |  |   |  |                     |                                  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) |   | 12b. KIND OF BUSINESS OR INDUSTRY  |   |  |                     |                                  |  |
| Rockville   |  | HEBREW HOME  |  |  |  | BROKER  |   | SUGAR IND.   |   |  |                     |                                  |  |
| 13a. STATE  |  |  |  |  | 13b. COUNTY  |   | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS |                                  |  |
| MD.   |  |  |  |  | MONTG  |   | ROCKVILLE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 6121 MONTROSE RD.   |                                  |  |
| 14. FATHER'S NAME   |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |   |   |  |   |  |                     |                                  |  |
| FIRST MIDDLE LAST<br>ABRAHAM --- SAVITSKY   |  |  |  |  | FIRST MIDDLE LAST<br>MOLLIE --- FOGEL  |   |   |  |   |  |                     |                                  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  |  |  | 16b. SOCIAL SECURITY NO.   |   | 17. INFORMANT   |  |   |  |                     |                                  |  |
| YES   |  |  |  |  | WW 11  |   | 103-10-1442 MRS. PEARL COHEN  |  |   |  |                     | 7508 OLD STAGE RD. ROCKVILLE MD. |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                     |                                  |  |
| IMMEDIATE CAUSE (a) <u>Terminal Ca. of the brain</u>  |  |  |  |  |  |   |   |  |   |  |                     |                                  |  |
| 1919 DUE TO, OR AS A CONSEQUENCE OF (b) <u>(Malignant Astrocytoma)</u>  |  |  |  |  |  |   |   |  |   |  |                     |                                  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last   |  |  |  |  |  |   |   |  |   |  |                     |                                  |  |
| DUE TO, OR AS A CONSEQUENCE OF (c)  |  |  |  |  |  |   |   |  |   |  |                     |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |  |  |   |   |  |   |  |                     |                                  |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                   |  |  |   | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |                     |                                  |  |
|   |  |  |  |  |  |   | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |                     |                                  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |   |  |                     |                                  |  |
|   |  |  | HOUR A.M. MONTH DAY YEAR<br>P.M. 19                                |  |  |   |   |  |   |  |                     |                                  |  |
| 21d. INJURY OCCURRED  |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION  |   |   |  |   |  |                     |                                  |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  |  |  |  | STREET CITY OR TOWN COUNTY STATE   |   |   |  |   |  |                     |                                  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/10</u> , 19 <u>83</u> , to <u>4/27</u> , 19 <u>83</u> that (I) (we) lost above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |   |  |   |  |                     |                                  |  |
| 22b. SIGNATURE  |  |  |  |  | DEGREE   |   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED                             |                     |                                  |  |
| <u>R. Shakir</u>  |  |  |  |  | MD   |   |   |  |   | <u>4/27/83</u>                               |                     |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  |  | 22e. ADDRESS   |   |   |  |   |  |                     |                                  |  |
| RAMLETH T.A. SHAKIR   |  |  |  |  |  |   |   |  |   |  |                     |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |   |   | 23d. LOCATION  |   |  |                     |                                  |  |
| BURIAL  |  |  | 4-28-83  |  | MT. ARARAT CEM.  |   |   | FARMINGDALE NEW YORK   |   |  |                     |                                  |  |
| 24. FUNERAL DIRECTOR  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR  |   |   | 25b. REGISTRAR'S SIGNATURE   |   |  |                     |                                  |  |
| DANZANSKY-GOLDBERG MEM CHP.   |  |  |  |  | MAY 2 1983   |   |   | <u>John J. Carver</u>  |   |  |                     |                                  |  |

39

EXHIBIT

Handwritten notes and signatures, including a large signature in the center.

CHIEF

20% COTTON



1914

NO. 10

LIBRARY OF THE

MISSISSIPPI STATE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. SIGN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |                      |  |  |  |   |  |  |  |  | REG. NO. 11077   |  |
|---|----------------------|--|--|--|---|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST <b>IRWIN</b> MIDDLE <b>SCHIFF</b> LAST <b>SCHIFF</b>   |                      |  |  |  |   |  |  |  |  | 2a. DATE KNOWN OF DEATH MONTH <b>10</b> DAY <b>30</b> YEAR <b>1983</b> |  |
| 3. SEX <b>Male</b>  | 4. RACE <b>White</b> | 5. DATE OF BIRTH MONTH <b>3</b> DAY <b>25</b> YEAR <b>57</b>   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>57</b> YRS. | IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>   | IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b> | 2c. DATE PRONOUNCED DEAD <b>April 30 1983</b>  |  | 2d. DATE OF DEATH MONTH <b>10</b> DAY <b>30</b> YEAR <b>1983</b>                 |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>   |                      | 7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery MD</b>                                    |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH <b>Sil Spg</b>  |                      | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hosp</b> |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Analyst</b>                 |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Navy Dept.</b>                              |  |  |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Mont</b>   |                      | 13b. COUNTY <b>Mont</b>  |  | 13c. CITY OR TOWN <b>Sil Spg</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS <b>20903 Rd 803 S. Belgrade Rd</b>                           |  |  |  |
| 14. FATHER'S NAME FIRST <b>Samuel</b> MIDDLE <b></b> LAST <b>Schiff</b>   |                      | 15. MOTHER'S MAIDEN NAME FIRST <b>Sylvia</b> MIDDLE <b></b> LAST <b>Kaminoff</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>  |   | 16b. SOCIAL SECURITY NO. <b>WW-2</b>   |  | 17. INFORMANT ADDRESS <b>Mrs. Sondra Schiff Same as No. 13</b>                   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4291</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b></b><br>(c) <b></b>  |                      |  |  |  |   |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                           |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>None</b>  |                      |  |  |  |   |  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>None</b>  |                      | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |   |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                      | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |                      | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                      |  |  |  |   |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John Rogers</b>   |                      | TITLE (SPECIFY) <b>DR. JOHN ROGERS, M. D.</b>  |  |  |   |  |  | DATE SIGNED <b>April 30, 1983</b>  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT)   |                      | ADDRESS <b>1919 SEMINARY ROAD SILVER SPRING, MARYLAND</b>  |  |  |   |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |                      | 23b. DATE <b>5/2/1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>King David Memorial Garden</b>   |   |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Falls Church, Virginia</b>            |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Donald M. Stein</b>  |                      | ADDRESS <b>232 Carroll Street, N. W.</b>   |  | CITY <b>Washington, D. C.</b>  |   | 25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE <b>J. L. Carter</b>                                   |  |  |  |



PLIBI



DR. Tauber released to Dr. Paul Noone

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 7 8

REG. NO.

|  |  |  |  |   |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  | 20. DATE OF DEATH  |  | MONTH DAY YEAR  |  | 26. HOUR  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | FIRST MIDDLE LAST  |  | April 2, 1983   |  | 1 46 A M  |  |
| Charlotte L. Schlosburg  |  |  |  |   |  |   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Female   |  | White  |  | MONTH DAY YEAR  |  | 69 YRS.   |  |
|  |  |  |  | May, 25 1913  |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| NEW YORK   |  | U.S.A.   |  |   |  | Montgomery MD.  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)                                     |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Bethesda   |  | Suburban Hospital  |  | SECRETARY   |  | MACHINES  |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. CITY OR TOWN   |  | 13d. INSIDE CITY LIMITS?  |  |
| MARYLAND   |  | MONTGOMERY   |  | ROCKVILLE   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 14. FATHER'S NAME  |  | 15. MOTHER'S MAIDEN NAME   |  | 13e. STREET ADDRESS   |  |   |  |
| FIRST MIDDLE LAST  |  | FIRST MIDDLE LAST  |  | 12103 PUTNAM ROAD   |  |   |  |
| HARRY  |  | LIEBOWITZ  |  | LENA  |  | KASRIEL   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT   |  | ADDRESS   |  |
| NO   |  | 053-01-4370  |  | DANIEL SCHLOSBERG,  |  | 12103 PUTNAM ROAD, ROCKVILLE, MARYLAND                              |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:  |  | IMMEDIATE CAUSE (a)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                        |  |
| 4100   |  | Myocardial infarction  |  | (b) Anteroseptal heart disease  |  | 1 hour  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.   |  | (c)  |  | DUE TO, OR AS A CONSEQUENCE OF  |  | 10-15 years   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)                |  | Benign squamous (Mid brain tumor)  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |
|  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) |  | 21b. TIME OF INJURY  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
|  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |   |  |
|  |  | P.M. 19  |  |   |  |   |  |
| 21d. INJURY OCCURRED   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION   |  |   |  |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from   |  | Mar 19 60, to  |  | 2 Apr 19 83, that (I) (we) lost   |  |   |  |
| saw the deceased alive on  |  | 30 Mar 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated                                  |  |   |  |   |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED  |  |   |  |
| Paul T. Noone MD   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | APRIL 2, 1983   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  |   |  |   |  |
| DR. PAUL T. NOONE, M. D.   |  | 50 W. EDMONSTON DRIVE, ROCKVILLE, MARYLAND   |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION   |  |
| BURIAL   |  | 1983 APRIL 3   |  | KING DAVID MEMORIAL GARDEN  |  | FALLS CHURCH, VIRGINIA  |  |
| 24. DONOR OF STEIN HEBREW MEMORIAL FUNERAL HOME  |  | 25a. ADDRESS   |  | 25b. BY REGISTERED REGISTRAR SIGNATURE  |  |   |  |
| 232 CARROLL STREET, N. W., WASHINGTON, D. C.   |  | 1800 18th Street NW  |  |   |  |   |  |

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RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8311079  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>MARIA E SEIDLER</b>   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>APRIL 2 1983</b>   |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>Feb 2, 1896</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS<br><b>87</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Germany</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Nurse Ret</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Nursing</b>   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>August Mickleit</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Unknown</b>   |  | 13e. STREET ADDRESS<br><b>15301 Aylsburys Street</b>  |  | 13f. STREET ADDRESS<br><b>20904</b>   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>101-30-3418</b>   |  | 17. INFORMANT<br><b>Gabriel Seidler-Son</b>   |  | ADDRESS<br><b>7309 6th Ave, Brooklyn, N.Y.</b>  |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>BIVENTRICULAR HEART FAILURE</b><br><b>4140</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>CORONARY HEART DISEASE</b><br>(c) <b>DUE TO, OR AS A CONSEQUENCE OF</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>WEEKS</b><br><b>YEARS</b>  |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)<br><b>LEFT CEREBRAL INFARCTION, anemia, arterial emboli</b>  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>March 11, 1983</b> to <b>April 2, 1983</b> , that (1) (we) lost <b>above</b> the deceased alive on <b>April 1, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did not view the body after death, so state.)      |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>Martin C. Shargel</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/2/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>MARTIN C. SHARGEL</b>  |  | 22e. ADDRESS<br><b>3720 FALLACUT AVE. KENSINGTON, MD - 20895</b>   |  |   |  |   |  |
| 23a. <del>XXX</del> CREMATION, <del>XXXX</del> (SPECIFY)<br><b>Cremation</b>   |  | 23b. DATE<br><b>Apr. 4, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Crematory</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Suitland P. G. Cty, Md.</b>   |  |
| 24. FUNERAL DIRECTOR NAME<br><b>W W CHAMBERS CO., 8653 Ga., Ave.</b>   |  | ADDRESS<br><b>S. S. Md.</b>  |  | 25a. DATE REGD. BY REGISTRAR<br><b>APR 10 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connelley</b>  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |   |   |  |  |   |  |  |
|---|--|---|--|---|---|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR  |  |   |  |   | REG. NO. 8311080  |   |  |  |   |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>MORRIS SELTZER  |  |   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 26, 1983                  |   |  | 2b. HOUR<br>7:00 a.m.  |   |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>August 19, 1908  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>74 YRS.                              |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.                        |   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Poland   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                  |  |  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3303 Glenmoor Drive |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>C.P.A. |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Auditing  |   |  |  |
| 13a. STATE<br>Maryland  |  |   |  |   | 13b. COUNTY<br>Montgomery   |   | 13c. CITY OR TOWN<br>Bethesda  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Simon Seltzer  |  |   |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Rifka Herman          |   |  |  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO   |  |   |  |   | 16b. SOCIAL SECURITY NO.<br>578-07-2352                             |   | 17. INFORMANT ADDRESS<br>Miriam Seltzer; 3303 Glenmoor Drive; Chevy Chase, Md. |  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u><br>4275 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Heart</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) |  |   |  |   |   |   |  |  |   |  |  |
| 19a. DATE OF OPERATION  |  |   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |  |   |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 <u>69</u> to 11-82, 19 <u>82</u> , that (I) (we) last saw the deceased alive on 11-82, 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |   |   |  |  |   |  |  |
| 22b. SIGNATURE<br><u>Irwin H. Ardham</u>  |  |   |  |   | 22c. DATE SIGNED<br>4-26-83   |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>IRWIN H. ARDAM, M.D.                        |   |  |  |
| 22e. ADDRESS<br>5454 Wisconsin Ave., Chevy Chase, Md.   |  |   |  |   | 22f. DATE SIGNED<br>APR 29 1983                                     |   |  |  |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial   |  |   |  |   | 23b. DATE<br>4/27/83  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>King David Mem. Gdn.                     |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Falls Church; Fairfax; Va.                           |  |  |
| 24. FUNERAL DIRECTOR<br>DANZANSKY-GOLDBERG MEMORIAL CHAPELS   |  |   |  |   | 25a. DATE REC'D BY REGISTRAR<br>APR 29 1983                         |   |  |  |   |  |  |
| 1170 Rockville Pike; Rockville, Maryland 20852  |  |   |  |   | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Carroll</u>                |   |  |  |   |  |  |





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 8 1

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH   |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>BARBARA C. SENGE</b>   |  | MONTH DAY YEAR <b>4 28 83</b>   |  | 9:15 P M   |  |
| 3. SEX <b>F Female</b>   | 4. RACE <b>X White</b>   | 5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 28, 1914</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.                                       |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>New York</b>  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>    |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County</b> MD.                    |  |
| 10. CITY OR TOWN OF DEATH <b>Takoma Park</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Washington Adventist Hosp.</b> | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>                                    |  |
| 13a. STATE <b>Maryland</b>   |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Sil. Spr.</b>   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Ralph Guy Cornell</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Leah Manzer</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>          |  |
| 16b. SOCIAL SECURITY NO. <b>577-20-8142</b>  |  | 17. INFORMANT <b>Irene A. Cornell: Stuart, Fla. 33497</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |   |  |  |  |
| PART I. DEATH WAS CAUSED BY:   |  |   |  |  |  |
| IMMEDIATE CAUSE (a) <b>Respiratory Failure</b>   |  |   |  |  |  |
| 5770 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Acute Pancreatitis</b>  |  |   |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <b>Cerebrovascular Thrombosis</b>   |  |   |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Azotemia</b>   |  |   |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>    |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)       |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                       |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Dec</b> , 19 <b>82</b> , to <b>April 28</b> , 19 <b>83</b> , that (I) (we) lost above, (I) (we) did (did not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE <b>Robert B. Grey</b>   |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED <b>4-29-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ROBERT B. GREY</b>  |  | 22e. ADDRESS <b>1161 New Hampshire Ave, Silver Spring, Md.</b>  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  | 23b. DATE <b>May 2, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery, Brentwood P. Geo. MD</b> |  |
| 24. FUNERAL DIRECTOR NAME <b>Warner E. Pumphrey, Inc.</b>  |  | P.O. Box 7428 <b>Sil. Spr., MD 20904</b>  |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b>                                      |  |
| 25b. REGISTRAR'S SIGNATURE <b>John J. Conner</b>   |  |   |  |  |  |

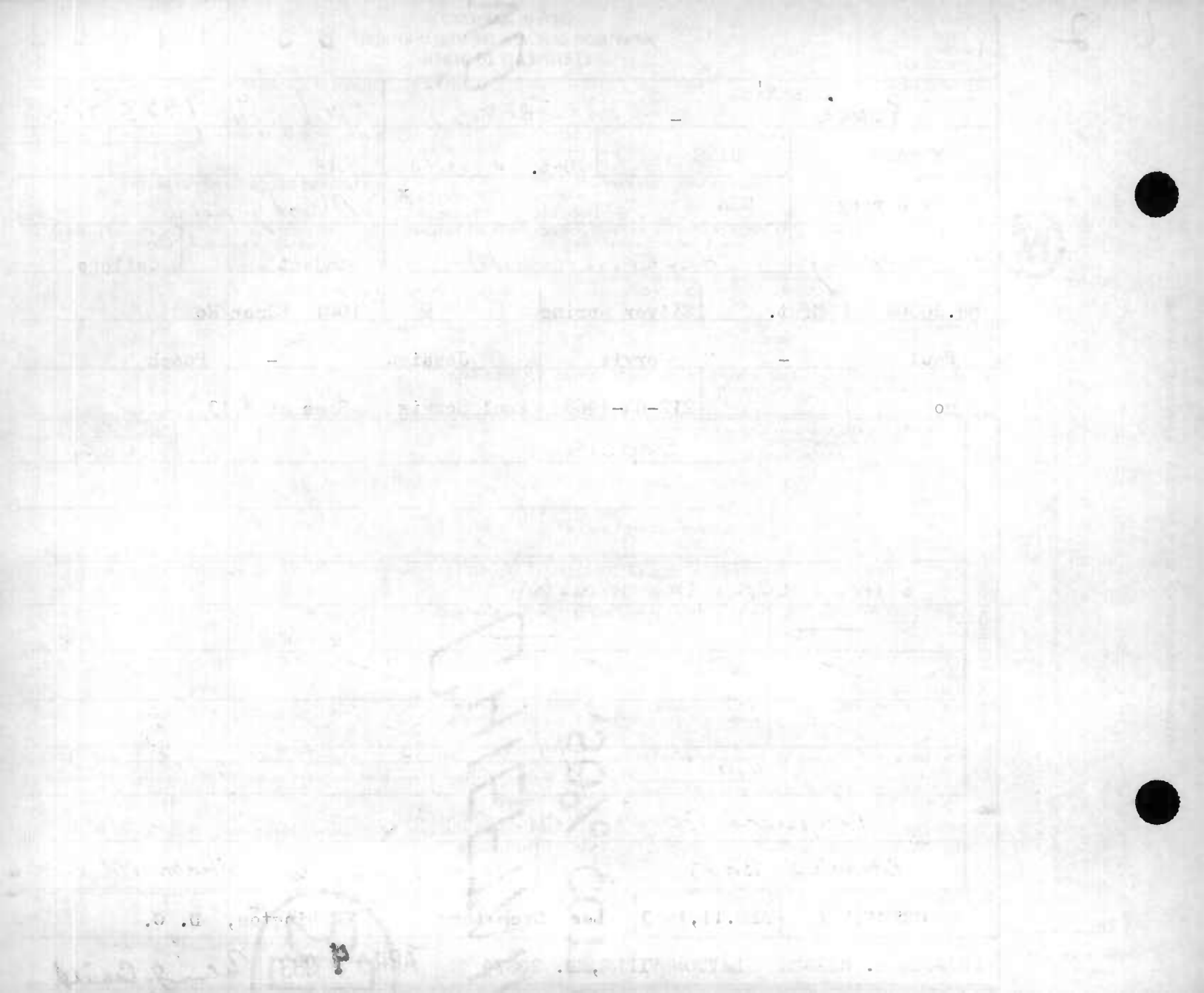
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |        |   |               |   |  |   |  |
|--|--|--|--------|---|---------------|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  | FIRST  | MIDDLE | LAST  | REG. NO.      |   |  |   |  |
| Renee  |  | RENEE  |        | Servis  | 8 3 1 1 0 8 2 |   |  |   |  |
| 2. SEX<br>FEMALE   |  | 4. RACE<br>WHITE   |        | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 4 1964   |               | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 9 1983   |  | 2b. HOUR<br>4:43 PM   |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br>New Jersey   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |        | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |               | 6. AGE (IN YEARS LAST BIRTHDAY)<br>18 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 72 HRS<br>HOURS MIN.   |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Rely Cross Hospital |        | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD   |               | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Student                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>College  |  |
| 13a. STATE<br>Md. 20904  |  | 13b. COUNTY<br>Mont.   |        | 13c. CITY OR TOWN<br>Silver Spring  |               | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>1001 Ednor Road 20904  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Paul - Servis  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Jessica - Posch   |        |   |               |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no   |  | 16b. SOCIAL SECURITY NO.<br>212-68-4968  |        | 17. INFORMANT<br>Paul Servis Same as # 13   |               |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Sepsis<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |  |        |   |               |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Systemic Lupus Erythematosus   |  |  |        |   |               |   |  |   |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |        |   |               | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |        | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |               |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |        | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |               |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/9 1983, to 4/9 1983, that (I) (we) lost saw the deceased alive on 4/9 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |  |        |   |               |   |  |   |  |
| 22b. SIGNATURE<br>Raymond Bass MD  |  |  |        | 22c. DATE SIGNED<br>4/9/83  |               |   |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>RAYMOND BASS   |  |
| 22e. ADDRESS<br>3929 Ferrara Dr. Wheaton, Md 20906   |  |  |        |   |               |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>CREMATION  |  | 23b. DATE<br>APR. 11, 1983   |        | 23c. NAME OF CEMETERY OR CREMATORY<br>Lee Crematory   |               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D. C.                                 |  |   |  |
| 24. FUNERAL DIRECTOR<br>FRANCIS H. BARBER LAYTONSVILLE, MD. 20879  |  |  |        | 25a. DATE RECEIVED BY REGISTRAR<br>APR 14 1983  |               | 25b. REGISTRAR'S SIGNATURE<br>John J. Carver  |  |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use on the burial/transit permit. This permit removes carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 8 3

1 - FOR  
STATE  
REGISTRAR

REG. NO.

|  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
|--|--|--|--|--|--|---|--|--|---|--|--|--|--|--|
| 1 DECEASED NAME<br>(TYPE OR PRINT)   |  |  | FIRST MIDDLE LAST  |  |  | 2a. DATE OF DEATH   |  |  | MONTH DAY YEAR  |  |  | 2b. HOUR   |  |  |
| MABEL D. SHACKELFORD   |  |  |  |  |  | APRIL   |  |  | 5 1983  |  |  | 9 <sup>20</sup> P <sup>M</sup>                       |  |  |
| 3 SEX  |  |  | 4 RACE   |  |  | 5. DATE OF BIRTH  |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |  | 7. IF UNDER 1 YEAR                                   |  |  |
| FEMALE   |  |  | White  |  |  | MONTH DAY YEAR  |  |  | 100   |  |  | YRS. MONTHS DAYS HOURS MIN.                          |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9 BALTIMORE CITY OR COUNTY OF DEATH                                 |  |  |  |  |  |
| Washington DC  |  |  | USA  |  |  |   |  |  | Montgomery  |  |  | MD.  |  |  |
| 10. CITY OR TOWN OF DEATH  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |
| Rockville  |  |  | NATIONAL LUTHERAN Home for the Aged  |  |  | RED Cross Supervisor  |  |  | Red Cross   |  |  |  |  |  |
| 13a. STATE   |  |  | 13b. COUNTY  |  |  | 13c. CITY OR TOWN   |  |  | 13d. INSIDE CITY LIMITS?  |  |  | 13e. STREET ADDRESS                                  |  |  |
| MARYLAND   |  |  | Montgomery   |  |  | Bethesda  |  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  | 5101 Ridgefield Rd                                   |  |  |
| 14 FATHER'S NAME   |  |  | 15. MOTHER'S MAIDEN NAME   |  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  |  | 16b. SOCIAL SECURITY NO.  |  |  | 17. INFORMANT (Gr-daughter) ADDRESS                  |  |  |
| GEORGE W.H. VAN HORN   |  |  | SUZANNE CALDWELL   |  |  | NO  |  |  | 280-40-5009   |  |  | Mary E. Stephens- 131 Lake Drive, Waldorf, Md. 20601 |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH         |  |  |
| IMMEDIATE CAUSE (a) RESPIRATORY FAILURE  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c)   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  | 20a. AUTOPSY?   |  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?      |  |  |  |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |  |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR   |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |   |  |  |  |  |  |
|  |  |  | P.M. 19  |  |  |   |  |  |   |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |  |  |  |
|  |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| 22a. I certify that (I) (we) attended the deceased from June 5, 1980, to Present, that (I) (we) last saw the deceased alive on April 5, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |  |   |  |  |  |  |  |
| 22b. SIGNATURE   |  |  | 22c. DATE SIGNED   |  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  | 22e. ADDRESS  |  |  |  |  |  |
| Thomas E. Dooley, MD   |  |  |  |  |  | Thomas E. Dooley, MD  |  |  | 2901 Olney-Sandy Spr. Road, Olney, Md.                              |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  |  | 23b. DATE  |  |  | 23c. NAME OF CEMETERY OR CREMATORY  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE                             |  |  |  |  |  |
| Burial   |  |  | 4-9-1983   |  |  | Glenwood Cemetery   |  |  | Washington, DC  |  |  |  |  |  |
| 24 FUNERAL DIRECTOR NAME   |  |  | 24b. ADDRESS   |  |  | 25a. DATE REC'D BY REGISTRAR  |  |  | 25b. REGISTRAR'S SIGNATURE  |  |  |  |  |  |
| Hines/Rinaldi Funeral Home   |  |  | 11800 N.H. Ave., S.S. Md. 20904  |  |  | APR 11 1983   |  |  | John J. Laniel  |  |  |  |  |  |

MEDICAL CERTIFICATION

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

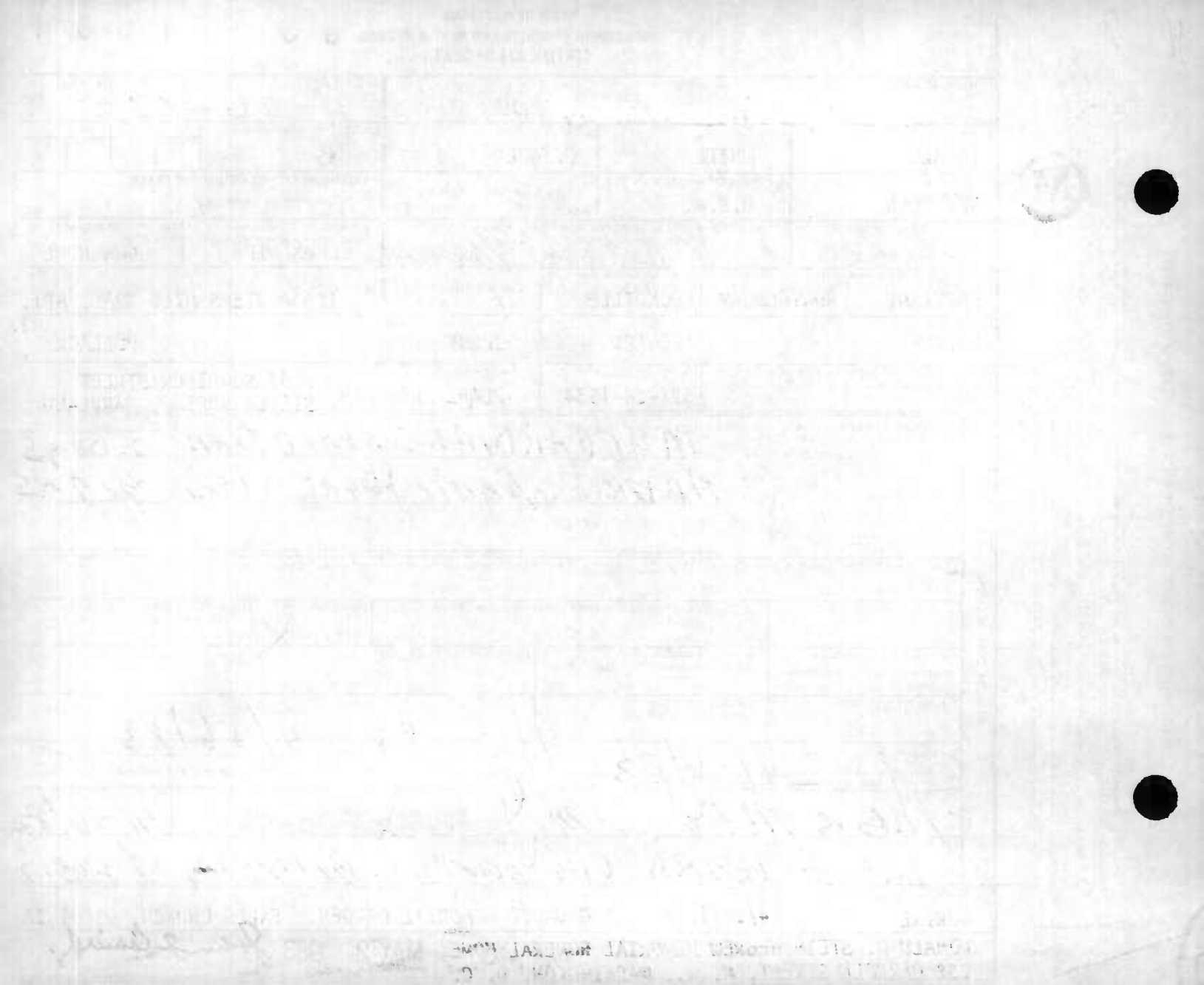
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |  |  |   |   |  |  |
|---|--|---|--|--|--|---|---|--|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  |   |  |  | 8 3 1 1 0 8 4<br>REG. NO.  |   |   |  |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>MARY SHANKMAN  |  |   |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>4-26-83                                    |   |   | 2b. HOUR<br>5:40 PM  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>WHITE  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>OCTOBER 3, 1897  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>85 YRS.  |   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.  |  |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>NEW YORK  |  | 9. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |   |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital Georgetown |  |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>HOUSEWIFE   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>OWN HOME  |  |
| 13a. STATE<br>MARYLAND  |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>ROCKVILLE   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS<br>12630 VIERS MILL ROAD, APT. 20852   |  |
| 14. FATHER'S NAME<br>HARRY FIRST MIDDLE LEONARD   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>JENNY FIRST MIDDLE POLLACK   |  |   |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>NO  |  |   |  | 16b. SOCIAL SECURITY NO.<br>578-24-1534  |  | 17. INFORMANT<br>PEARL SHANKMAN, 8207 SCHRIDER STREET, SILVER SPRING, MARYLAND  |   |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 2 DAYS<br>4100 DUE TO, OR AS A CONSEQUENCE OF (b) ARTERIO SCLEROTIC HEART DISEASE 4 YEARS<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c)   |  |   |  |  |  |   |   |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)   |  |   |  |  |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |   |   |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |   |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from 4/23/83 to 4/26/83, that (1) (my) last saw the deceased alive on 4/26/83, and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above; (1) (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) (k) (l) (m) (n) (o) (p) (q) (r) (s) (t) (u) (v) (w) (x) (y) (z) (aa) (ab) (ac) (ad) (ae) (af) (ag) (ah) (ai) (aj) (ak) (al) (am) (an) (ao) (ap) (aq) (ar) (as) (at) (au) (av) (aw) (ax) (ay) (az) (ba) (bb) (bc) (bd) (be) (bf) (bg) (bh) (bi) (bj) (bk) (bl) (bm) (bn) (bo) (bp) (bq) (br) (bs) (bt) (bu) (bv) (bw) (bx) (by) (bz) (ca) (cb) (cc) (cd) (ce) (cf) (cg) (ch) (ci) (cj) (ck) (cl) (cm) (cn) (co) (cp) (cq) (cr) (cs) (ct) (cu) (cv) (cw) (cx) (cy) (cz) (da) (db) (dc) (dd) (de) (df) (dg) (dh) (di) (dj) (dk) (dl) (dm) (dn) (do) (dp) (dq) (dr) (ds) (dt) (du) (dv) (dw) (dx) (dy) (dz) (ea) (eb) (ec) (ed) (ee) (ef) (eg) (eh) (ei) (ej) (ek) (el) (em) (en) (eo) (ep) (eq) (er) (es) (et) (eu) (ev) (ew) (ex) (ey) (ez) (fa) (fb) (fc) (fd) (fe) (ff) (fg) (fh) (fi) (fj) (fk) (fl) (fm) (fn) (fo) (fp) (fq) (fr) (fs) (ft) (fu) (fv) (fw) (fx) (fy) (fz) (ga) (gb) (gc) (gd) (ge) (gf) (gg) (gh) (gi) (gj) (gk) (gl) (gm) (gn) (go) (gp) (gq) (gr) (gs) (gt) (gu) (gv) (gw) (gx) (gy) (gz) (ha) (hb) (hc) (hd) (he) (hf) (hg) (hh) (hi) (hj) (hk) (hl) (hm) (hn) (ho) (hp) (hq) (hr) (hs) (ht) (hu) (hv) (hw) (hx) (hy) (hz) (ia) (ib) (ic) (id) (ie) (if) (ig) (ih) (ii) (ij) (ik) (il) (im) (in) (io) (ip) (iq) (ir) (is) (it) (iu) (iv) (iw) (ix) (iy) (iz) (ja) (jb) (jc) (jd) (je) (jf) (jg) (jh) (ji) (jj) (jk) (jl) (jm) (jn) (jo) (jp) (jq) (jr) (js) (jt) (ju) (jv) (jw) (jx) (jy) (jz) (ka) (kb) (kc) (kd) (ke) (kf) (kg) (kh) (ki) (kj) (kk) (kl) (km) (kn) (ko) (kp) (kq) (kr) (ks) (kt) (ku) (kv) (kw) (kx) (ky) (kz) (la) (lb) (lc) (ld) (le) (lf) (lg) (lh) (li) (lj) (lk) (ll) (lm) (ln) (lo) (lp) (lq) (lr) (ls) (lt) (lu) (lv) (lw) (lx) (ly) (lz) (ma) (mb) (mc) (md) (me) (mf) (mg) (mh) (mi) (mj) (mk) (ml) (mn) (mo) (mp) (mq) (mr) (ms) (mt) (mu) (mv) (mw) (mx) (my) (mz) (na) (nb) (nc) (nd) (ne) (nf) (ng) (nh) (ni) (nj) (nk) (nl) (nm) (nn) (no) (np) (nq) (nr) (ns) (nt) (nu) (nv) (nw) (nx) (ny) (nz) (oa) (ob) (oc) (od) (oe) (of) (og) (oh) (oi) (oj) (ok) (ol) (om) (on) (oo) (op) (oq) (or) (os) (ot) (ou) (ov) (ow) (ox) (oy) (oz) (pa) (pb) (pc) (pd) (pe) (pf) (pg) (ph) (pi) (pj) (pk) (pl) (pm) (pn) (po) (pp) (pq) (pr) (ps) (pt) (pu) (pv) (pw) (px) (py) (pz) (qa) (qb) (qc) (qd) (qe) (qf) (qg) (qh) (qi) (qj) (qk) (ql) (qm) (qn) (qo) (qp) (qq) (qr) (qs) (qt) (qu) (qv) (qw) (qx) (qy) (qz) (ra) (rb) (rc) (rd) (re) (rf) (rg) (rh) (ri) (rj) (rk) (rl) (rm) (rn) (ro) (rp) (rq) (rr) (rs) (rt) (ru) (rv) (rw) (rx) (ry) (rz) (sa) (sb) (sc) (sd) (se) (sf) (sg) (sh) (si) (sj) (sk) (sl) (sm) (sn) (so) (sp) (sq) (sr) (ss) (st) (su) (sv) (sw) (sx) (sy) (sz) (ta) (tb) (tc) (td) (te) (tf) (tg) (th) (ti) (tj) (tk) (tl) (tm) (tn) (to) (tp) (tq) (tr) (ts) (tt) (tu) (tv) (tw) (tx) (ty) (tz) (ua) (ub) (uc) (ud) (ue) (uf) (ug) (uh) (ui) (uj) (uk) (ul) (um) (un) (uo) (up) (uq) (ur) (us) (ut) (uu) (uv) (uw) (ux) (uy) (uz) (va) (vb) (vc) (vd) (ve) (vf) (vg) (vh) (vi) (vj) (vk) (vl) (vm) (vn) (vo) (vp) (vq) (vr) (vs) (vt) (vu) (vv) (vw) (vx) (vy) (vz) (wa) (wb) (wc) (wd) (we) (wf) (wg) (wh) (wi) (wj) (wk) (wl) (wm) (wn) (wo) (wp) (wq) (wr) (ws) (wt) (wu) (wv) (ww) (wx) (wy) (wz) (xa) (xb) (xc) (xd) (xe) (xf) (xg) (xh) (xi) (xj) (xk) (xl) (xm) (xn) (xo) (xp) (xq) (xr) (xs) (xt) (xu) (xv) (xw) (xx) (xy) (xz) (ya) (yb) (yc) (yd) (ye) (yf) (yg) (yh) (yi) (yj) (yk) (yl) (ym) (yn) (yo) (yp) (yq) (yr) (ys) (yt) (yu) (yv) (yw) (yx) (yy) (yz) (za) (zb) (zc) (zd) (ze) (zf) (zg) (zh) (zi) (zj) (zk) (zl) (zm) (zn) (zo) (zp) (zq) (zr) (zs) (zt) (zu) (zv) (zw) (zx) (zy) (zz) |  |   |  |  |  |   |   |  |  |
| 22b. SIGNATURE<br>Thos B. Ward  |  |   | 22c. DATE SIGNED<br>4/26/83  |  |  | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   |  |  |
| 23a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Thos B. Ward   |  |   | 23b. ADDRESS<br>6116 Robinwood, Bethesda, Md 20817                     |  |  |   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  |   | 23b. DATE<br>4/29/1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>KING DAVID MEMORIAL GARDEN               |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>FALLS CHURCH VIRGINIA |  |  |
| 24. FUNERAL DIRECTOR<br>DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME<br>232 CARROLL STREET, N. W., WASHINGTON, D. C.  |  |   |  |  | 25. DATE REC'D. BY REGISTRAR<br>MAY 2 1983 REGISTRAR SIGNATURE                 |   |   |  |  |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 8 5

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |  |   |   |  |
|---|--|---|---|--|---|--|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HELEN M. SHARPE</b>  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR <b>4 18 83</b>                     |  |   | 2b. HOUR <b>9<sup>05</sup> P<sup>M</sup></b>   |   |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |   | 5. DATE OF BIRTH MONTH DAY YEAR <b>5 20 11</b>   |   | 6. AGE (IN YEARS LAST BIRTHDAY) <b>71</b> YRS.   |   | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Quincy, Illinois</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b>   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>MONTGOMERY</b> MD.   |   |   |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy CROSS HOSPITAL</b> |   |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |   | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE <b>Maryland</b>  |  | 13b. COUNTY <b>Montgomery</b>   |   | 13c. CITY OR TOWN <b>Silver Spring</b>   |   | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e. STREET ADDRESS <b>2015-Forest Hill Drive</b> <b>20903</b>  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles William Maddex</b>   |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Elizabeth vonTersch</b>  |   |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>   |  |   |   | 16b. SOCIAL SECURITY NO. <b>212-68-3008</b>  |   | 17. INFORMANT ADDRESS <b>Silver Spring, MD 20903</b>   |   |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>MECHANICAL ADENOCARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>MONTHS</b>  |   |  |   |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |   |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>         |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |   |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |   |   |  |
| 22a. I certify that (a) this hospital attended the deceased from <b>APRIL 19 82</b> to <b>APRIL 19 83</b> that (b) (we) last saw the deceased alive on <b>APRIL 19 83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.  |  |   |   |  |   |  |   |   |  |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>MILTON KOCH</b>  |  |   | DEGREE <b>MD</b>  |  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED <b>4/19/83</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>  |  |   | 23b. DATE <b>April 19, 1983</b>                                     |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Lee's Crematory</b> |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Washington, D.C.</b> |   |  |
| 24. FUNERAL DIRECTOR <b>J. Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002</b>  |  |   |   |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 25 1983</b>          |  |   |   |  |
|   |  |   |   |  | 25b. REGISTRAR'S SIGNATURE <b>Joan T. Canine</b>          |  |   |   |  |

MEDICAL CERTIFICATION



1992, 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 26

2000

1941, 1942, 1943

D.C. 1959

U.S. Coast Guard Auxiliary, USCGC-07000





*[Faint, mostly illegible text covering the majority of the page, appearing to be a letter or report.]*

MAY 10 1962

U.S. DEPARTMENT OF AGRICULTURE



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |  |  |  |   |  |                           | 8311087  |  |
|--|--|--|--|--|--|--|---|--|---------------------------|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  | REG. NO.   |  |   |  |                           |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  |  |  |  | 2a. DATE OF DEATH  |  |   |  |                           | 2b. HOUR   |  |
| FIRST MIDDLE LAST<br>EVA. (NMN) SHERMAN  |  |  |  |  | MONTH DAY YEAR<br>4 11 83  |  |   |  |                           | 1 30 M   |  |
| 3. SEX   |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS (LAST BIRTHDAY))  |   | 7. IF UNDER 1 YEAR   |                           | 7. IF UNDER 24 HRS.                                      |  |
| Female   |  | Caucasian  |  | Dec. 24, 1896  |  | 86   |   | MONTHS DAYS  |                           | HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |   |  |                           |  |  |
| Virginia   |  | U.S.A.   |  |  |  | Montgomery MD.   |   |  |                           |  |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                  |   | 12b. KIND OF BUSINESS OR INDUSTRY                              |                           |  |  |
| Kensington   |  | Circle Manor Nursing Home  |  |  |  | Homemaker Ret.   |   | At Home  |                           |  |  |
| 13a. STATE   |  |  | 13b. COUNTY  |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS?  |  | 13e. STREET ADDRESS       |  |  |
| Maryland   |  |  | Montgomery   |  | Kensington   |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 10231 Carroll Place 20875 |  |  |
| 14. FATHER'S NAME  |  |  |  |  | 15. MOTHER'S MAIDEN NAME   |  |   |  |                           |  |  |
| FIRST MIDDLE LAST<br>Unknown   |  |  |  |  | FIRST MIDDLE LAST<br>Unknown   |  |   |  |                           |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)  |  |  |  |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS   |  |                           |  |  |
| No   |  |  |  |  | None   |  | 578-01-1504 William H. Koehler, Friend S.S.Md. 20902                |  |                           |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>0389 IMMEDIATE CAUSE (a) Septicemia<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b)<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |  |  |  |  |  |   |  |                           | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>48 hours |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br>Atherosclerosis, Coronary Artery Disease  |  |  |  |  |  |  |   |  |                           |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a. AUTOPSY?  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |                           |  |  |
|  |  |  |  |  |  | YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | YES <input type="checkbox"/> NO <input type="checkbox"/>       |                           |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |                           |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                              |   |  |                           |  |  |
| 22a. I certify that (1) this hospital attended the deceased from 4-13-83 to 4-11-83, and that (2) (we) (we) lost saw the deceased alive on April 4, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.   |  |  |  |  |  |  |   |  |                           |  |  |
| 22b. SIGNATURE   |  |  |  |  | DEGREE   |  |   |  |                           | 22c. DATE SIGNED   |  |
| Benjamin Franklin, MD  |  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |   |  |                           | April 11, 1983   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  |  |  |  | 22e. ADDRESS   |  |   |  |                           |  |  |
| Benjamin Franklin, MD  |  |  |  |  | 3720 Prospect Hill Ave. Kensington, Md.  |  |   |  |                           |  |  |
| 23a. BURIAL (SPECIFY)  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY  |  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                     |                           |  |  |
| Burial   |  |  | Apr. 13, 1983  |  | Prospect Hill Cemetery   |  |   | Washington, D. C.  |                           |  |  |
| 24. FUNERAL DIRECTOR NAME  |  |  |  |  | 25a. DATE RECEIVED BY  |  |   |  |                           | 25b. REGISTRAR'S SIGNATURE                               |  |
| W. W. CHAMBERS CO. 8655 Ga. Ave. SS, Md. 20910   |  |  |  |  | APR 11 1983  |  |   |  |                           | John J. Conner   |  |

BP





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |   |  |   |  |  | 8 3 1 1 0 8 8 |  |
|---|--|--|--|---|---|--|---|--|--|---------------|--|
| 1. FOR STATE REGISTRAR  |  |  |  |   |   |  |   |  |  | REG. NO.      |  |
| 1. DECEASED NAME (TYPE OR PRINT)<br>ESTHER W. SILVERSTEIN   |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 30, 1983            |  |   | 2b. HOUR<br>3:27am   |  |               |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>April 28, 1916   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>68 yrs YRS.                                       |   | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>New York   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                        |   |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital ER |  |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife           |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |               |  |
| 13a. STATE<br>Maryland  |  |  |  |   | 13b. CITY OR TOWN<br>Chevy Chase                              |  | 13c. STREET ADDRESS<br>8105 Ellingson Dr. 20815 |  |  |               |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>Abraham Wassreman  |  |  |  |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Dora Zieman     |  |   |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>No   |  |  | 16b. SOCIAL SECURITY NO.<br>219-46-6445          |   | 17. INFORMANT ADDRESS<br>Husband, Julius 8105 Ellingson Drive |  |   |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Cardiac arrest</u><br>4100<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <u>Probable acute myocardial infarction</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) <u>Arteriosclerotic Heart Disease</u> |  |  |  |   |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>1 hour</u><br><u>Known since March 17, 1980</u> |               |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:<br><u>Chronic Renal disease with hypertension</u>   |  |  |  |   |   |  |   |  |  |               |  |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |   |  |  |               |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |   |  |   |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>March 17</u> , 19 <u>80</u> , to <u>April 30</u> , 19 <u>83</u> , that (I) (we) lost the deceased alive on <u>April 28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.  |  |  |  |   |   |  |   |  |  |               |  |
| 22b. SIGNATURE<br><u>Aaron H. Traum MD</u>  |  |  |  | DEGREE<br>MD  |   |  |   | 22c. DATE SIGNED<br>April 30 1983  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>AARON H. TRAUM MD  |  |  |  | 22e. ADDRESS<br>8915 Georgia Ave Silver Spring MD 20910   |   |  |   |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Removal  |  | 23b. DATE<br>4/30/1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Georgetown Med. School  |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Washington, D.C.                          |   |  |  |               |  |
| 24. FUNERAL DIRECTOR NAME<br>Columbia Mortuary Services, Inc.<br>225 Missouri Ave. NW Washington, D.C. 20011  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 5 1983   |   |  |   |  |  |               |  |
| 25b. REGISTRAR'S SIGNATURE<br><u>John J. Connel</u>   |  |  |  |   |   |  |   |  |  |               |  |

MEDICAL CERTIFICATION

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGES 1, 2, AND 3 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                     |   |   |   |                               |   |                               |
|---|---------------------|---|---|---|-------------------------------|---|-------------------------------|
| 1. FOR<br>STATE<br>REGISTRAR  |                     | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRIET<br/>HARRIETXXX</b>                 |   | MIDDLE<br><b>M.</b>   | LAST<br><b>SIMMEL</b>         | 2a. DATE KNOWN<br>OF DEATH<br>ESTIMATED<br><input checked="" type="checkbox"/> MONTH<br><input type="checkbox"/> DAY<br><input type="checkbox"/> YEAR<br><b>4 23 83</b> | 2b. HOUR<br>AM<br><b>9:45</b> |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>W</b> | 5. DATE OF BIRTH<br>MONTH<br><b>12</b><br>DAY<br><b>21</b><br>YEAR<br><b>1924</b> | 6. AGE IN YEARS<br>(LAST BIRTHDAY)<br><b>58</b> | 7c. DATE<br>PRONOUNCED<br>DEAD<br><b>4-23 83</b>  | 7d. HOUR<br>AM<br><b>9:45</b> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b>   |                               |
| 7a. BIRTHPLACE (STATE OR<br>FOREIGN COUNTRY)<br><b>WASHINGTON, D. C.</b>  |                     | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>                                     |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |                               | 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |                               |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>SUBURBAN HOSPITAL</b>  |                     |   |   | 12a. USUAL OCCUPATION (TYPE OF WORK<br>FOR MOST OF WORKING LIFE)<br><b>EXECUTIVE SECRETARY</b>  |                               | 12b. KIND OF BUSINESS<br>OR INDUSTRY  |                               |
| 13a. STATE<br><b>MARYLAND</b>   |                     |   |   | 13b. COUNTY<br><b>MONTGOMERY</b>  |                               | 13c. CITY OR TOWN<br><b>ROCKVILLE</b>   |                               |
| 14. FATHER'S NAME<br>FIRST<br><b>HARRY</b><br>MIDDLE<br><b>L.</b><br>LAST<br><b>STONEBRUNER</b>   |                     |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST<br><b>KATHARINE</b><br>MIDDLE<br><b>J.</b><br>LAST<br><b>BURROUGHS</b>  |                               |   |                               |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>NO</b>  |                     | 16b. SOCIAL SECURITY NO.<br><b>579-42-2730</b>                                    |   | 17. INFORMANT<br><b>DAUGHTER</b><br><b>CHRISTIE FERRI</b>   |                               |   |                               |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>1729 Cardio respiratory arrest</b><br>Conditions, if any, which<br>gave rise to immediate<br>cause (a) stating the under-<br>lying cause last.<br>(b) <b>metastatic melanoma</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____  |                     | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH                                   |   |   |                               |   |                               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |                     |   |   |   |                               |   |                               |
| 19a. DATE OF OPERATION  |                     | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                                 |   |   |                               | 20. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                               |
| 21a. EXTERNAL CAUSE WAS<br>UNDERLYING <input type="checkbox"/> OR<br>CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |                     | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>                 |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |                               |   |                               |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |                     | 21e. PLACE OF INJURY (AT HOME,<br>STREET, FACTORY, FARM, ETC.)                    |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                               |   |                               |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion<br>death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |                     |   |   |   |                               |   |                               |
| ACTUAL<br>SIGNATURE <b>John Tanber</b>  |                     | TITLE (SPECIFY)<br>M.D. _____ MEDICAL EXAMINER                                    |   |   |                               | DATE<br>SIGNED <b>4-23-83</b>   |                               |
| EXAMINER'S NAME<br>(TYPE OR PRINT) <b>John Tanber</b>   |                     | ADDRESS <b>6218 Wisconsin ave.</b>  |   |   |                               |   |                               |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>BURIAL</b>  |                     | 23b. DATE<br><b>4/26/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKLAWN CEMETERY</b>  |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROCKVILLE MONT MD.</b>   |                               |
| 24. FUNERAL DIRECTOR<br>NAME <b>FRANCIS J. COLLINS</b><br>ADDRESS <b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>  |                     |   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 28 1983</b>   |                               | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>   |                               |



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO.   |  |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | 11090  |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Anna Simon</b>   |  |  |  |  |  |  |  |  |  | 20. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>4</b> DAY <b>3</b> YEAR <b>1983</b> |  |
| 3. SEX <b>F</b> 4. RACE <b>W</b> 5. DATE OF BIRTH MONTH <b>12</b> DAY <b>15</b> YEAR <b>06</b> 6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS. 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Russia</b> 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> |  |  |  |  |  |  |  |  |  | 21. DATE PRONOUNCED DEAD MONTH <b>4</b> DAY <b>3</b> YEAR <b>1983</b>                                    |  |
| 10. CITY OR TOWN OF DEATH <b>Gaithersburg</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b> 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Operator (Ret.)</b> 12b. KIND OF BUSINESS OR INDUSTRY <b>Ladies Garmm</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 13a. STATE <b>New York</b> 13b. COUNTY <b>Bronx</b> 13c. CITY OR TOWN <b>Bronx</b> 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 13e. STREET ADDRESS <b>14014 Debbs Place</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 14. FATHER'S NAME FIRST <b>Morris</b> MIDDLE <b>Saltzman</b> LAST <b>Hilda</b> 15. MOTHER'S MAIDEN NAME FIRST <b>Hilda</b> MIDDLE <b>(unknown)</b> LAST <b>(unknown)</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>101-26-3198</b> 17. INFORMANT ADDRESS <b>Potomac, Md.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4100 Ventricular Fibrillation</b><br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>acute Respiratory Failure</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>acute myocardial infarction</b>  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |  |  |  |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |  |  |  |  |  |  |  |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |  |  |  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |  |  |  |  |  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>                       |  |  |  |  |  |  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John J. Gann</b> M.D. TITLE (SPECIFY) <b>Medical Examiner</b> DATE SIGNED <b>4-3-83</b>  |  |  |  |  |  |  |  |  |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John J. Gann</b> ADDRESS <b>8218 Wisconsin ave.</b>   |  |  |  |  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b> 23b. DATE <b>4-6-1983</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b> 23d. LOCATION CITY OR TOWN <b>Glendale, New York</b> COUNTY STATE   |  |  |  |  |  |  |  |  |  |  |  |
| 24. FUNERAL DIRECTOR NAME <b>Danzansky-Goldberg Chapels; 1170 Rockville Pike</b> ADDRESS <b>Rockville, Md.</b> 25a. DATE REC'D. BY REGISTRAR <b>APR 11 1983</b> REGISTRAR'S SIGNATURE <b>John J. Gann</b>  |  |  |  |  |  |  |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept by the funeral director, page 3 by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |   |  |   |   |  |
|---|--|--|--|--|---|--|---|---|--|
| 1. FOR Items 21a thru 22a<br>STATE REGISTRAR Film 579 5-11-83 cn  |  |  |  |  | 8 3 1 1 0 9 1<br>REG. NO.   |  |   |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>FLOBA JANE Simons   |  |  |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 8 25 83  |  |   | 2b. HOUR<br>12 40 AM  |  |
| 3. SEX<br>FEMALE  |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>DEC 16, 1899   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>INDIANA  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.                               |   |   |  |
| 10. CITY OR TOWN OF DEATH<br>TAKOMA PARK  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>WASHINGTON ADVENTIST HOSPITAL |  |  |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>SECRETARY        |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>FRUIT GROWERS EXP.   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br>MARYLAND PRI. GEORGES LANHAM   |  |  |  |  | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13c. STREET ADDRESS<br>7505 ELBROOK COURT 20706 |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>LEONIDAS PARKS  |  |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>JANE RANDOLPH                                  |  |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>577-30-5117   |  | 17. INFORMANT<br>FAYE L. CLARK   |   |  | ADDRESS<br>SAME AS 13 DAUGHTER                  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Respiratory Failure</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Aspiration</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Staphylococcus Aureus Resp. Infection</u> |  |  |  |  |   |  |   |   | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><u>2-3 days</u><br><u>1-2 weeks</u><br><u>5 weeks</u> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><u>Renal Failure</u>  |  |  |  |  |   |  |   |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>Pt. p.m. Had N.G. tube  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>feeding aspiration occurred from NG tube contents contributing to pulmonary infection not unusual in elderly semi-comatose pt |   |  |   |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br>Not considered an injury   |  | 21f. LOCATION<br>19 22 to 19 23  |   | 21g. DATE OF DEATH<br>APRIL 24 19 83   |   |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. <u>Natural</u>  |  |  |  |  |   |  |   |   |  |
| 22b. SIGNATURE<br><u>Robert B. Trey</u>   |  |  |  | DEGREE<br>MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |   |  |   | 22c. DATE SIGNED<br>4-25-83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>ROBERT B. TREY   |  |  |  | 22e. ADDRESS<br>11161 New Hampshire Ave, Silver Spring, Md.  |   |  |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>BURIAL  |  | 23b. DATE<br>4/27/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>CEDAR HILL CEMETERY  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>SUITLAND PRI GEO MD.                   |   |   |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>FRANCIS J. COLLINS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 28 1983   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Canfield</u>                                |   |   |  |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 9 2

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT)   |  | 2a. DATE OF DEATH   |  | 2b. HOUR  |  |
|   |  | Genevieve C. Smith  |  | April 26, 1983  |  | 9 PM  |  |
| 3. SEX  |  | 4. RACE   |  | 5. DATE OF BIRTH  |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  |
| Female  |  | Caucasian   |  | June 23, 1901   |  | 81 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |
| Pennsylvania  |  | United States   |  |   |  | Montgomery County MD.   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |
| Bethesda  |  | Suburban Hospital   |  | Bookkeeper  |  | Mining  |  |
| 13a. STATE  |  | 13b. COUNTY   |  | 13c. CITY OR TOWN   |  | 13d. STREET ADDRESS   |  |
| Maryland  |  | Montgomery  |  | Rockville   |  | 1603 Farragut Ave. 20850  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)  |  | 16b. SOCIAL SECURITY NO.  |  |
| James   |  | Anna  |  | No  |  | 203-20-0587   |  |
| 17. INFORMANT   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Coronary Arteriosclerosis -</u><br><u>5533</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <u>Upper Gastrointestinal Hemorrhage</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <u>Fracture/Hernia &amp; Swelling</u><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>20 minutes</u><br><u>3 weeks</u><br><u>years</u> |  | 17. INFORMANT   |  | ADDRESS   |  |
| Grace Smith, Daughter, Same as item #13   |  | 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?   |  |
|   |  |   |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?   |  |
|   |  |   |  |   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>            |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |
|   |  |   |  |   |  |   |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>October 1962</u> to <u>7/24 1983</u> , that (we) last saw the deceased alive on <u>4/24 1983</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (do not) view the body after death. |  | 22b. SIGNATURE<br><u>H.C. Moore</u><br>DEGREE <u>MD</u>   |  | 22c. DATE SIGNED<br><u>4/27/83</u>  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS  |  | 22f. DATE REC'D. BY REGISTRAR   |  | 22g. REGISTRAR'S SIGNATURE  |  |
| H.C. Moore  |  | 501 E. Church St. Rockville, MD   |  | MAY 2 1983  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)  |  | 23b. DATE   |  | 23c. NAME OF CEMETERY OR CREMATORY  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                          |  |
| Burial  |  | April 30, 1983  |  | St. Mary's Cemetery   |  | Mt. Carmel, Pennsylvania  |  |
| 24. FUNERAL DIRECTOR<br>NAME  |  | 24b. DATE REC'D. BY REGISTRAR   |  | 24c. REGISTRAR'S SIGNATURE  |  |   |  |
| Robert A. Pumphrey Funeral Homes,<br>P.A., Bethesda, Maryland   |  | MAY 2 1983  |  |   |  |   |  |



1. The purpose of this report is to provide a summary of the results of the investigation conducted during the period from January 1, 1962, to December 31, 1962.

2. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

3. The results of the investigation are summarized in the following paragraphs:

4. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

5. The results of the investigation are summarized in the following paragraphs:

6. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

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9. The results of the investigation are summarized in the following paragraphs:

10. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

11. The results of the investigation are summarized in the following paragraphs:

12. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

13. The results of the investigation are summarized in the following paragraphs:

14. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

15. The results of the investigation are summarized in the following paragraphs:



16. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

17. The results of the investigation are summarized in the following paragraphs:

18. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

19. The results of the investigation are summarized in the following paragraphs:

20. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

21. The results of the investigation are summarized in the following paragraphs:

22. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

23. The results of the investigation are summarized in the following paragraphs:

24. The investigation was conducted in accordance with the plan of work approved by the Office of Management and Organization, Department of the Army, on January 1, 1962.

25. The results of the investigation are summarized in the following paragraphs:

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 (VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |  |  |  |   |  |   |  |   |  |
|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR <b>Dorothea E. Solloway</b>  |  |   |  |  |  |   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Dorothea E Solloway</b>   |  |   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>April 12-1983</b>                             |  |   | 2b. HOUR <b>7:47 P.M.</b>                        |   |  |
| 3. SEX <b>female</b>  |  | 4. RACE <b>caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Sept. 29, 1888</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>94</b> YRS                                     |  | IF UNDER 1 YEAR MONTHS DAYS   |  | IF UNDER 24 HRS. HOURS MIN.                 |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Baltimore, Md.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery County, MD.</b>                |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Rockville,</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>National Lutheran Home for the Aged</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>    |  |   | 12b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b> |   |  |
| 13a. STATE <b>Maryland</b>  |  |   |  | 13b. COUNTY <b>Baltimore Co.</b>   |  | 13c. CITY OR TOWN <b>Baltimore</b>  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  | 13e. STREET ADDRESS <b>2701 The Alameda</b> |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas G. Solloway</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Regina K. Hollar</b>   |  |   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>   |  |   |  | 16b. SOCIAL SECURITY NO. <b>216-10-7190 A</b>  |  | 17. INFORMANT ADDRESS <b>Rev. Richard Reichard 9701 Veirs Dr. Rockville, Md.</b>  |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. <b>2639 IMMEDIATE CAUSE (a) <u>Insanition</u></b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |  |  |   |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <b>gangrene of feet.</b>   |  |   |  |  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>March 21, 1968</b> to <b>April 12, 1983</b> , that (I) (we) lost saw the deceased alive on <b>April 11, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |   |  |  |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Harold F. McCann, M.D.</b> DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |   |  |  |  | 22c. DATE SIGNED <b>4-13-83</b>   |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>HAROLD F. MCCANN</b>   |  |   |  |  |  | 22e. ADDRESS <b>3355-16th St. N.W. Wash, D.C. 20010</b>                           |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>April 15, 1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore, Maryland</b>                |  |   |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>The Hysong Company</b> ADDRESS <b>1300 N St. N.W. Washington, D.C.</b>   |  |   |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 27 1983</b>                                  |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Connel</b>  |  |   |  |

November 1, 1950

Dear Sirs:

I am writing to you regarding the National Institute of Standards and Technology (NIST) and the National Bureau of Standards (NBS). The NIST is a part of the Department of Commerce, and the NBS is a part of the NIST. The NIST is responsible for the development and maintenance of the National Standard System, and the NBS is responsible for the development and maintenance of the National Standard System. The NIST and the NBS are both part of the National Standard System, and they are both responsible for the development and maintenance of the National Standard System. The NIST and the NBS are both part of the National Standard System, and they are both responsible for the development and maintenance of the National Standard System.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                      |  |  |  |                                  |  |  |  | REG. NO. 11094   |  |
|--|--|----------------------|--|--|--|----------------------------------|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <b>CHRISTOPHER E. SORRELL, Sr.</b>  |  |                      |  |  |  |                                  |  |  |  | 2a. DATE KNOWN OF DEATH <b>4-10-83</b>                           |  |
| 3. SEX <b>male</b>   |  | 4. RACE <b>White</b> |  | 5. DATE OF BIRTH <b>11-16-15</b>   |  | 6. AGE (IN YEARS) <b>67</b> YRS. |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN  |  | 2b. DATE PRONOUNCED DEAD <b>4-10-83</b>                          |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Washington, D.C.</b>  |  |                      |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>  |  |                                  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. <b>BALTIMORE CITY OR COUNTY OF DEATH</b> <b>Montgomery MD</b> |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>   |  |                      |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b> |  |                                  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired Clerk</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>I.R.S.</b>                  |  |
| 13a. STATE <b>Maryland</b>   |  |                      |  |  |  |                                  |  |  |  | 13b. CITY OR TOWN <b>College Park</b>                            |  |
| 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                      |  |  |  |                                  |  |  |  | 13d. STREET ADDRESS <b>4701 Kiernan Rd</b>                       |  |
| 13e. ZIP CODE - <b>20740</b>   |  |                      |  |  |  |                                  |  |  |  |  |  |
| 14. FATHER'S NAME <b>Christopher A. Sorrell</b>  |  |                      |  | 15. MOTHER'S MAIDEN NAME <b>Mary Sullivan</b>  |  |                                  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes-Army</b>   |  |                      |  | 16b. SOCIAL SECURITY NO. <b>W.W.II 578-40-9264</b>   |  |                                  |  | 17. INFORMANT <b>Mrs. Annie E. Sorrell</b> ADDRESS <b>Address Same as No# 13c.</b>   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>4291 Acute Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) <b>Chronic Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Yrs.</b>  |  |                      |  |  |  |                                  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH.                    |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <b>None</b>   |  |                      |  |  |  |                                  |  |  |  |  |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |                      |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |                                  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |                      |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>  |  |                                  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |                      |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  |                                  |  | 21f. LOCATION CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . |  |                      |  |  |  |                                  |  |  |  |  |  |
| ACTUAL SIGNATURE <b>John S. Rogers, M.D.</b>   |  |                      |  | TITLE (SPECIFY) <b>MD</b>  |  |                                  |  | MEDICAL EXAMINER   |  |  |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers, M.D.</b>  |  |                      |  | ADDRESS <b>1919 Seminary Rd. Silver Springs, Md.</b>   |  |                                  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>  |  |                      |  | 23b. DATE <b>4/13/83</b>   |  |                                  |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>   |  |  |  |
| 23d. LOCATION CITY OR TOWN <b>Brentwood</b>  |  |                      |  | COUNTY <b>P.G.</b> STATE <b>Maryland</b>   |  |                                  |  |  |  |  |  |
| 24. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b>  |  |                      |  |  |  |                                  |  |  |  |  |  |
| 25. REGISTRAR'S SIGNATURE <b>John S. Rogers</b>  |  |                      |  |  |  |                                  |  |  |  |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department. Page 3 should be filed with the funeral home. Page 4 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical investigation must be conducted.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 8 3 1 1 0 9 5  |  | REG. NO.   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MIDDLE LAST  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |   |  |
| EMOGENE O. SPATES   |  |  |  | (4-5-83) 04-05 83  |  | 430 P   |  | M   |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |  |
| Female  |  | white  |  | 11 19 32   |  | 50 YRS.   |  |   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH  |  |   |  |
| North Carolina  |  | U.S.A.   |  |  |  | MONTGOMERY MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |   |  |
| SILVER SPRING   |  | Holy Cross Hospital of Silver Spring   |  | Secretary  |  | Dept of AG  |  |   |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. STATE   |  | 13c. CITY OR TOWN  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS                                     |  |
| MD  |  | PR. GEORGE   |  | Beltsville   |  | YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 11612 34th PL 20705                                     |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  |  |  |   |  |   |  |
| ROBERT LEWIS ORR  |  | IDA R. LYDAY   |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |   |  |   |  |
| NO  |  | 237-40-5589  |  | CHARLES W. SPATES, JR.   |  | SAME AS 13 HUSBAND  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH            |  |
| IMMEDIATE CAUSE (a) Sepsis  |  |  |  |  |  |   |  | 4 days  |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Neutropenia / Bone marrow mets   |  |  |  |  |  |   |  | 2 wks   |  |
| (c) Breast Cancer   |  |  |  |  |  |   |  | 2 yrs   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |  |  |  |   |  |   |  |
| Bone mets, Liver mets, Heart Failure  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)                                    |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/5 1983, to 4/5 1983, that (we) last saw the deceased on 4/5 1983, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED  |  |   |  |
| Peter B. Sherer   |  | MD   |  |  |  |   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  | 22e. ADDRESS   |  |  |  |   |  |   |  |
| Peter B. Sherer   |  | 3947 Ferrara Dr. Wheaton, Md   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE   |  |   |  |
| BURIAL  |  | 4/10/83  |  | DAVIDSON-RIVER CEMETERY  |  | PISGAH FOREST   |  | N. CAROLINA   |  |
| 24. FUNERAL DIRECTOR NAME   |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  | 25b. REGISTRAR'S SIGNATURE  |  |   |  |
| FRANCIS J. COLLINS  |  | 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901  |  | APR 14 1983  |  | John J. Casper  |  |   |  |

BP

THE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |   | REG. NO.<br>83 11096             |  |
|--|--|--|---|---|----------------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Lillian Trott Spicknall</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 9, 1983</b> |   | 2b. HOUR<br>P M<br><b>5:45 P</b> |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>Feb. 16, 1902</b>  |                                  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                                  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |
| 10. CITY OR TOWN OF DEATH<br><b>Gaithersburg</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Herman Wilson Health Care Center</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Teacher</b>  |                                  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Schools</b>  |
| 13a. STATE<br><b>Md. 20877</b>   |  | 13b. COUNTY<br><b>Montgomery</b>   |   | 13c. CITY OR TOWN<br><b>Gaithersburg</b>  |                                  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Alexander -- Durfee</b>   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna -- (Unknown)</b>  |   | 13e. STREET ADDRESS<br><b>401 Russell Avenue</b>  |                                  | <b>20877</b>   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>212-36-3383</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>John Turnbull Spicknall, Same address as #13.</b>  |                                  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Respiratory arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Carcinoma of Colon</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |  |   |   |                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).   |  |  |   |   |                                  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |                                  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |                                  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                                  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from <b>Apr. 7, 1983</b> to <b>Apr. 9, 1983</b> , that (I) (we) last saw the deceased alive on <b>Apr. 7, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.   |  |  |   |   |                                  |  |
| 22b. SIGNATURE<br><b>Tibor E. Frekko MD</b><br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |   | 22c. DATE SIGNED<br><b>4-9-83</b>   |                                  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Tibor E. Frekko MD</b>   |  |  |   | 22e. ADDRESS<br><b>19211 Mont. Village Ave., Gaithersburg, Md.</b>  |                                  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/13/83</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park Cemetery</b>   |                                  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore, Maryland</b>   |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Joseph Gawler's Sons, Inc.<br/>5130 Wisconsin Ave., NW, Washington, D.C. 20016</b>  |  |  |   | 25a. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b> REGISTRAR'S SIGNATURE <b>John J. Connel</b>  |                                  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of page 1.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 0 9 7

REG. NO.

1. FOR  
STATE  
REGISTRAR1. DECEASED NAME  
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Bessie LITMAN Springer

2a. DATE OF DEATH

MONTH

DAY

YEAR

2b. HOUR

4-1-83 9:23 M

3. SEX

FEMALE

4. RACE

WHITE

5. DATE OF BIRTH

MONTH

DAY

YEAR

1-01-11

6. AGE (IN YEARS LAST BIRTHDAY)

72

IF UNDER 1 YEAR

MONTHS

DAYS

IF UNDER 24 HRS

HOURS

MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)

RUSSIA

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED

NEVER MARRIED

WIDOWED

DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery MD.

10. CITY OR TOWN OF DEATH

Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION

Holy Cross Hospital

12a. USUAL OCCUPATION

TEACHER

12b. KIND OF BUSINESS OR INDUSTRY

EDUCATION

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE

13b. COUNTY

13c. CITY OR TOWN

13d. INSIDE CITY LIMITS?

YES ☒ NO ☐

13e. STREET ADDRESS

2015 WINDHAM LANE

20702

14. FATHER'S NAME

JACOB

MIDDLE

LAST

LITMAN

15. MOTHER'S MAIDEN NAME

GUSSIE

MIDDLE

LAST

(UNASCERTAINABLE)

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?

YES, NO OR UNKNOWN

NO

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

161-36-1595

17. INFORMANT

JEFFREY SPRINGER, 2015 WINDHAM LANE, SILVER SPRING, MARYLAND

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

0119

DUE TO, OR AS A CONSEQUENCE OF

(b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

7 Hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

MEDICAL CERTIFICATION

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

YES ☐ NO ☒

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?

YES ☐ NO ☒21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION

STREET

CITY OR TOWN

COUNTY

STATE

22a. I certify that (I) (this hospital) attended the deceased from 3/21/83, 19, to 4/1, 1983, that (I/we) have  
saw the deceased alive on 4/1/83, 19, and that in my (our) opinion death occurred on the date and hour and from the causes stated  
above. (I/we) (did/did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN

MEDICAL DIRECTOR

STAFF PHYSICIAN

22c. DATE SIGNED

4/2/83

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

C. P. O. H. M.

22e. ADDRESS

10620 6th Ave SE RM

23a. BURIAL, CREMATION, REMOVAL

BURIAL

23b. DATE

4/5/1983

23c. NAME OF CEMETERY OR CREMATORY

ADAS ISRAEL CONGREGATION CEMETERY

23d. LOCATION

WASHINGTON

STATE

24. FUNERAL HOME OR

DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME  
232 CARROLL STREET, N. W., WASHINGTON, D. C.

APR 8 1983

25. DIRECTOR OF HEALTH AND MENTAL HYGIENE

26. REGISTRAR'S SIGNATURE

John G. B. B. B.

S.P. 1-11

January 1st 1933



11-12

1933

Let it all go

1933

CHALK

COLORED





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 11098

REG. NO.

FOR  
1- STATE  
REGISTRAR

|   |  |   |  |  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Bessie J. Spinks</i>   |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>April 26 1983</i> |  |  | 2b. HOUR<br><i>9:48 P.M.</i>                                  |  |
| 3. SEX<br><i>Female</i>   |  | 4. RACE<br><i>White</i>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>Jan. 20 1915</i>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>68</i> YRS.             |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTY)<br><i>Virginia</i>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><del>MARRIED</del> <del>DIVORCED</del> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD. |  |
| 10. CITY OR TOWN OF DEATH<br><i>Silver Spring</i>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Holy Cross Hospital</i> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>Homemaker</i>                                 |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><i>Own home</i>          |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY CITY OR TOWN<br><i>Maryland Montgomery Silver Spring</i> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><i>112 Bonifant Road 20904</i>  |  |   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Frank Wince</i>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Lena Spicer</i>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NOT KNOWN) (IF YES, GIVE SERVICE DATES)<br><i>N/A</i>   |  | 16b. SOCIAL SECURITY NO.<br><i>228-28-7163</i>  |  | 17. INFORMANT<br>ADDRESS<br><i>June Bartholow-daughter- (same as 13e)</i>  |  |   |  |

|   |  |   |
|---|--|---|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>Stroke</i><br><i>1629</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <i>Brainogenic carcinoma</i><br>(c) <i>Invasive ADH</i> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>2 days</i><br><i>7 years</i><br><i>1 month</i> |
|---|--|---|

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:6

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |
| 22a. I certify that (I (this hospital) attended the deceased from <i>11/20/82</i> 19 <i>83</i> to <i>11/26/83</i> 19 <i>83</i> , that (I (we) lost saw the deceased alive on <i>11/26/83</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><i>[Signature]</i>  |  | DEGREE<br><i>M.D.</i>  |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><i>22 Nov 83</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>Michael Libowitz, MD</i>  |  |  |  | 22e. ADDRESS<br><i>1120 New Hampshire Ave SE, NE 20204</i>  |  |  |  |

|  |  |                               |  |  |  |   |  |
|--|--|-------------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial</i> |  | 23b. DATE<br><i>4-25-1983</i> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><i>Parklawn Cemetery</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Rockville Montgomery Md.</i> |  |
| 24. FUNERAL DIRECTOR<br><i>Hines/Rinaldi Funeral Home</i>  |  |                               |  | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 26 1983</i>            |  | 25b. REGISTRAR'S SIGNATURE<br><i>[Signature]</i>                              |  |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1

68

RECEIVED  
FEDERAL BUREAU OF INVESTIGATION  
U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535



FILED

20% GOLF

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. See also may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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BP

DHMH-16 25M  
(VRA 15, 4) 1/79

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 3 1 1 0 9 9  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT) GERTRUDE H. STEARMAN  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR April 3, 1983   |  |   |  |
| 3 SEX Female  |  |   |  | 2b. HOUR 7:12 PM   |  |   |  |
| 4 RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR December 13, 1908                           |  | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.  |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.  |  | 7b. CITIZEN OF WHAT COUNTRY? U. S. A.                                       |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION HOLY CROSS HOSPITAL |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |
| 13a. STATE Maryland   |  | 13b. COUNTY Prince Georges  |  | 13c. CITY OR TOWN Silver Spring  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jacob H. Haas   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary (Unknown)                   |  | 13e. STREET ADDRESS 20903 8500 New Hampshire Ave., #230  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No  |  | 16b. SOCIAL SECURITY NO 578-10-8463   |  | 17. INFORMANT ADDRESS Max Stearman Same as No. 13  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) Chronic obstructive Pulmonary Disease<br>4960<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):  |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                            |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19                        |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)          |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 1, 1983, to April 3, 1983, that (I) (we) lost saw the deceased alive on 4/3/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.   |  |   |  |  |  |   |  |
| 22b. SIGNATURE Bernard A. Heckman, M.D.   |  | DEGREE  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED 4/4/1983   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) BERNARD A. HECKMAN, M. D.   |  | 22e. ADDRESS 8830 Cameron St., Silver Spring, Maryland                      |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL SPECIAL Burial  |  | 23b. DATE 4/6/1983  |  | 23c. NAME OF CEMETERY OR CREMATORY Mount Lebanon Cemetery  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Adelphi, Pr. Geo., Maryland   |  |
| 24. FUNERAL DIRECTOR OR NAME Donald M. Stein  |  | 24b. ADDRESS 232 Carroll Street, N. Washington, D.C.                        |  | 25a. DATE REC'D. BY REGISTRAR APR 8 1983   |  | 25b. REGISTRAR'S SIGNATURE J. J. Conish   |  |

1945



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 1 0 0

REG. NO.

|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Harry H. Steidle</b>   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>4-28-83</b>   |  | 2b. HOUR <b>6<sup>05</sup> P.M.</b>   |  |
| 3. SEX <b>Male</b>  |  | 4. RACE <b>White</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>Feb. 26 1897</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>86</b> YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Penna.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Suburban Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Secretary</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Pre Fab Home Trade Assn</b>  |  |
| 13a. STATE <b>Md. 20906</b>   |  | 13b. COUNTY <b>Montgomery</b>   |  | 13c. CITY OR TOWN <b>Silver Spring</b>  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>George W. Steidle</b>  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Katherine Hoffman</b>   |  | 13e. STREET ADDRESS <b>3213 Ludhaw Drive</b>  |  | 20906   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>  |  | 16b. SOCIAL SECURITY NO. <b>WW1</b>   |  | 17. INFORMANT <b>Patricia J. Steidle. Same as item 13.</b>  |  | ADDRESS   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Cardiorespiratory arrest</b><br><b>4360</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Stroke</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>DUE TO, OR AS A CONSEQUENCE OF |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION <b>4/27/83</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>STROKE</b>  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/28</b> 19 <b>83</b> , to <b>4/28</b> 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>4/28</b> 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.                      |  |   |  |   |  |   |  |
| 22b. SIGNATURE <b>Louis Kozloff M.D.</b>  |  |   |  | DEGREE  |  | 22c. DATE SIGNED  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>LOUIS KOZLOFF, M.D.</b>  |  |   |  | 22e. ADDRESS <b>3218 WISCONSIN AVE. BETHESDA, MD. 20814</b>   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>   |  | 23b. DATE <b>5/2/1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Quantico National Cem.</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Quantico Virginia</b>  |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR <b>MAY 3 1983</b>   |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Conish</b>  |  |
| 5130 Wisc. Ave., N.W. Wash., D. C.  |  |   |  |   |  |   |  |

MEDICAL CERTIFICATION



Male  
Age  
Date of Birth  
U.S.A.

Montgomery  
M. 2000  
Address  
City

Female  
Age  
Date of Birth  
U.S.A.

Male  
Age  
Date of Birth  
U.S.A.

Female  
Age  
Date of Birth  
U.S.A.

Male  
Age  
Date of Birth  
U.S.A.

Female  
Age  
Date of Birth  
U.S.A.

Male  
Age  
Date of Birth  
U.S.A.

Female  
Age  
Date of Birth  
U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on file.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |   |   |  |  | 8311101 |  |
|--|--|--|--|---|--|---|---|--|--|---------|--|
| 1- FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |  |   |   |  |  |         |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Nancy Carol Stewart</b>  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 29, 1983</b>                                   |   |   | 2b. HOUR<br><b>7:27p</b> M   |  |         |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 14, 1936</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>46</b> YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |         |  |
| 7a. BIRTHPLACE<br>(STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |   |  |  |         |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>The Clinical Center, NIH</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |   | 12b. KIND OF BUSINESS OR INDUSTRY  |  |         |  |
| 13a. USUAL RESIDENCE<br>(IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>DC</b>   |  | 13c. CITY OR TOWN<br><b>Glendale Hts</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 13e. STREET ADDRESS<br><b>10013 Franklin Ave. East</b> 20769   |  |         |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>William Diehl</b>   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Anna Mae Reibel</b>                        |   |   |  |  |         |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |  |  |   | 16b. SOCIAL SECURITY NO.<br><b>183-28-5283</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Thomas V. Stewart, son, same</b> |  |  |         |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>2019 IMMEDIATE CAUSE (a) <b>Cardiorespiratory Arrest</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }<br>(b) <b>Upper gastrointestinal hemorrhage</b> 1 day<br>(c) <b>End stage hodgkins disease</b> 3 years  |  |  |  |   |  |   |   |  |  |         |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |  |   |  |   |   |  |  |         |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                       |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |         |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                  |   |  |  |         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |         |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>15 April</b> , 19 <b>83</b> , to <b>29 April</b> , 19 <b>83</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>29 April</b> , 19 <b>83</b> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) <del>not</del> view the body after death. |  |  |  |   |  |   |   |  |  |         |  |
| 22b. SIGNATURE<br><b>Brent C. Behrens</b>  |  |  |  |   | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>4/30/83</b>                              |  |  |         |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>BRENT C. BEHRENS MD.</b>   |  |  |  |   | 22e. ADDRESS<br><b>The Clinical Center, National Institutes of Health, Bethesda, Md. 20205</b> |   |   |  |  |         |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  |  | 23b. DATE<br><b>May 3, 1983</b>  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>MD. Nat'l. Mem. Prk Laurel, P.G., Maryland</b>        |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE                      |  |  |         |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>Howard Hale's Lanham F.H. Lanham, MD</b>  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 9 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Lawler</i>             |  |  |         |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |  |  | 8 3 1 1 1 0 2 |  |
|--|--|--|---|--|--|---|--|--|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  | REG. NO.  |  |  |   |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)  |  |  | FIRST<br>OPAL   |  |  | MIDDLE<br>RUTH  |  |  | LAST<br>STEWART  |               |  |
| 2. DATE OF DEATH   |  |  | MONTH<br>APRIL  |  |  | DAY<br>14   |  |  | YEAR<br>1983   |               |  |
| 3. SEX<br>FEMALE   |  |  | 4. RACE<br>CAUCASIAN  |  |  | 5. DATE OF BIRTH<br>MAY 14 DAY 1929   |  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>53  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>KENTUCKY  |  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES   |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY   |               |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA  |  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NAVAL HOSPITAL   |  |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>WATTRESS  |  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>RESTAURANT  |               |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>FLORIDA  |  |  | 13b. CITY OR TOWN<br>ORANGE   |  |  | 13c. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  | 13d. STREET ADDRESS<br>ROUTE 10, BOX 791 Jupiter St.   |               |  |
| 14. FATHER'S NAME<br>OTIS  |  |  | 15. MOTHER'S MAIDEN NAME<br>BEULAH  |  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>NO  |  |  | 16b. SOCIAL SECURITY NO.<br>273-26-9604  |               |  |
| 17. INFORMANT<br>BEULAH BLACKBURN  |  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>0389 IMMEDIATE CAUSE (a) Sepsis SEPSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a |  |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH   |  |  |  |               |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |               |  |
| 21a. ACCIDENT WAS UNDERLYING<br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 14 APRIL 83 to 14 APRIL 83, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  | 22b. SIGNATURE<br>Michael S. Gurney   |  |  | 22c. DEGREE<br>MD   |  |  | 22d. DATE SIGNED<br>4/15/83  |               |  |
| 22a. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MICHAEL S. GURNEY, LT, MC, USNR   |  |  | 22e. ADDRESS<br>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND<br>NATIONAL CAPITAL REGION, BETHESDA, MD 20814  |  |  | 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>Apr. 19, 1983   |               |  |
| 23c. NAME OF CEMETERY OR CREMATORY<br>Chapel Hill Cemetery   |  |  | 23d. LOCATION<br>CITY OR TOWN<br>Orlando, Fla.  |  |  | 24. FUNERAL DIRECTOR<br>NAME<br>Capitol Funeral Service, Falls Church, Va.  |  |  | 25. DATE RECD. BY REGISTRAR<br>APR 25 1983   |               |  |
| 25. REGISTRAR'S SIGNATURE<br>John J. Canine  |  |  |   |  |  |   |  |  |  |               |  |

RECEIVED



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RECEIVED

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8311103   |  |  |  |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Rufus Cornelius Stubblefield   |  |  |  | April 20, 1983   |  |  |  |
| 3 SEX<br>Male  |  | 4 RACE<br>White  |  | 5 DATE OF BIRTH MONTH DAY YEAR<br>March 22, 1983   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>100  |  |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Arkansas   |  | 7b CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.  |  |
| 10 CITY OR TOWN OF DEATH<br>Silver Spring  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (AS NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>14701 Peach Orchard Road |  | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>carpenter  |  | 12b KIND OF BUSINESS OR INDUSTRY<br>construction   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a STATE<br>Md   |  |  |  | 13b COUNTY<br>Montgomery   |  | 13c CITY OR TOWN<br>Silver Spring  |  |
| 14 FATHER'S NAME FIRST MIDDLE LAST<br>William Tipton Stubblefield  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>Nancy Elizabeth Dalton   |  |  |  |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>no   |  | 16b SOCIAL SECURITY NO<br>431 03 7162  |  | 17 INFORMANT ADDRESS<br>A Willene Keenum same as above   |  |  |  |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Congestive heart failure</u><br>4280<br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>advanced age</u><br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |  |  |  |  |  |  |
| 19a DATE OF OPERATION  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |
| 21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK  |  | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>August 19 79</u> to <u>20 April 19 83</u> , that (1) (we) lost saw the deceased alive on <u>19 April 19 83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.                            |  |  |  |  |  |  |  |
| 22b SIGNATURE<br>Carol Jean Smith, MD  |  |  |  | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>       |  | 22c DATE SIGNED<br>20 April 83   |  |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>CAROL JEAN Smith, MD.  |  |  |  | 22e ADDRESS<br>15612 Good Hope Rd, Silver Spring, Md 20904   |  |  |  |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b DATE<br>April 23, 1983   |  | 23c NAME OF CEMETERY OR CREMATORY<br>Union Cemetery  |  | 23d LOCATION CITY OR TOWN COUNTY STATE<br>Burtonsville, Md   |  |
| 24 FUNERAL DIRECTOR NAME<br>Donaldson Funeral Home, ADDRESS<br>Laurel, Md  |  |  |  | 25a DATE REC'D BY REGISTRAR BY REGISTRAR'S SIGNATURE<br>APR 29 1983 John J. Chisholm   |  |  |  |

April 20, 1983

Washington

Correspondence

100

April 22, 1983

Outstanding

X

Outstanding

100

Construction

Outstanding

April 22, 1983

Outstanding

April 22, 1983

X

Outstanding

100

January 1983

January 1983

April 22, 1983

100

100

April 22, 1983

April 22, 1983

April 22, 1983

April 22, 1983

April 22, 1983

April 22, 1983

April 22, 1983

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 1 0 4

1. FOR  
STATE  
REGISTRAR

REG. NO.

|   |   |   |  |   |  |
|---|---|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Helen E Sturgess</b> |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 15, 1983</b> |   | 2b. HOUR<br><b>5:16P M</b>                                       |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>CAUCASIAN</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 11 07</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>76</b> YRS.   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.                                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Clerk-Retired</b>        |  |
| 13a. STATE<br><b>MD.</b>  |   | 13b. COUNTY<br><b>HOWARD</b>  | 13c. CITY OR TOWN<br><b>COLUMBIA</b>                         | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>LORIE NURSING HOME</b>                 |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Ralph A. Payne</b>                     |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lillian M. Soper</b>  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>577-01-2631</b>  |  | 17. INFORMANT<br><b>Anne M. Teter</b>   |  |
|   |   |   |  | 17. ADDRESS<br><b>13738 Briaridge Ct<br/>Highland, Md. 20777</b>                                |  |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

3109

IMMEDIATE CAUSE (a) **SEPSIS**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) **SACRAL DECUBITUS ULCER**

DUE TO, OR AS A CONSEQUENCE OF

(c) **ORGANIC BRAIN SYNDROME**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**FRACTURED PELVIS, FRACTURED HIP**

|   |  |  |  |  |   |
|---|--|--|--|--|---|
| 19a. DATE OF OPERATION<br><b>-</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |   |
| 22a. I certify that (1) (this hospital) attended the deceased from <b>3/8</b> , 19 <b>83</b> , to <b>4/15</b> , 19 <b>83</b> , that (1) (we) last saw the deceased alive on <b>4/15</b> , 19 <b>83</b> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. |  |  |  |  |   |
| 22b. SIGNATURE<br><i>Evelyn Jackson</i>   |  | DEGREE   |  | 22c. DATE SIGNED<br><b>4/15/83</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Evelyn Jackson, M.D.</b>  |  | 22e. ADDRESS<br><b>5540 Ten Oaks Road, Clarksville, MD. 21029</b>      |  |  |   |

|   |                                 |  |   |
|---|---------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b> | 23b. DATE<br><b>18Apr. 1983</b> | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Suitland PG Maryland</b> |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert E. Wilhelm</b>      |                                 | ADDRESS<br><b>Funeral Home Inc</b>                               | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 22 1983</b>                       |
|   |                                 | REGISTRAR'S SIGNATURE<br><i>John J. Canine</i>                   |   |

UNITED STATES



PHILIPPINES



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1- FOR STATE REGISTRAR  |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 3 1 1 1 0 5<br>REG. NO.  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Mildred C Swagart</b>  |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4/23/83</b>   |  |  |  | 2b. HOUR<br><b>3:35 A</b> M  |  |  |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>April 9 1895</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>88</b>   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Washington D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                         |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |  |  |
| 13a. STATE<br><b>Md. 20015</b>  |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Chevy Chase</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>4701 Willard Ave.</b>  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Bernard Emmert</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Dora (Unknown)</b>  |  |  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>   |  |   |  | 16b. SOCIAL SECURITY NO.<br><b>577-28-0972</b>  |  | 17. INFORMANT ADDRESS<br><b>Gayle Manning 9621 Accord Dr., Potomac, Md.</b>          |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Hyponatremia + GI Obstruction</b><br><b>1589</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Electrolyte Disturbance</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Spontaneous Peritonitis</b> |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 mo +</b><br><b>1 mo.</b><br><b>1 year</b>                             |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>None</b>  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>April 22</b> , 19 <b>83</b> , to <b>April 23</b> , 19 <b>83</b> , that (I) (we) lost saw the deceased alive on <b>April 22</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br><b>W. H. Luckatt</b>  |  |   |  | DEGREE <b>MD</b>  |  |  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/23/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>W. H. Luckatt</b>   |  |   |  | 22e. ADDRESS<br><b>5000 Penn Rd NW Washington, D.C.</b>   |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  |   |  | 23b. DATE<br><b>4/26/1983</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Gate of Heaven Cemetery</b>                 |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Silver Spring Md.</b>   |  |  |  |
| 24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons Inc.</b>   |  |   |  |   |  | 25a. DATE REC'D BY REGISTRAR<br><b>APR 27 1983</b>                                   |  | 25b. REGISTRAR'S SIGNATURE<br><b>Joan J. Canfield</b>  |  |  |  |
| 24. NAME ADDRESS<br><b>5130 Wisc. Ave., N.W. Wash., D.C.</b>  |  |   |  |   |  |  |  |  |  |  |  |

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185 | 186 | 187 | 188 | 189 | 190 | 191 | 192 | 193 | 194 | 195 | 196 | 197 | 198 | 199 | 200 | 201 | 202 | 203 | 204 | 205 | 206 | 207 | 208 | 209 | 210 | 211 | 212 | 213 | 214 | 215 | 216 | 217 | 218 | 219 | 220 | 221 | 222 | 223 | 224 | 225 | 226 | 227 | 228 | 229 | 230 | 231 | 232 | 233 | 234 | 235 | 236 | 237 | 238 | 239 | 240 | 241 | 242 | 243 | 244 | 245 | 246 | 247 | 248 | 249 | 250 | 251 | 252 | 253 | 254 | 255 | 256 | 257 | 258 | 259 | 260 | 261 | 262 | 263 | 264 | 265 | 266 | 267 | 268 | 269 | 270 | 271 | 272 | 273 | 274 | 275 | 276 | 277 | 278 | 279 | 280 | 281 | 282 | 283 | 284 | 285 | 286 | 287 | 288 | 289 | 290 | 291 | 292 | 293 | 294 | 295 | 296 | 297 | 298 | 299 | 300 | 301 | 302 | 303 | 304 | 305 | 306 | 307 | 308 | 309 | 310 | 311 | 312 | 313 | 314 | 315 | 316 | 317 | 318 | 319 | 320 | 321 | 322 | 323 | 324 | 325 | 326 | 327 | 328 | 329 | 330 | 331 | 332 | 333 | 334 | 335 | 336 | 337 | 338 | 339 | 340 | 341 | 342 | 343 | 344 | 345 | 346 | 347 | 348 | 349 | 350 | 351 | 352 | 353 | 354 | 355 | 356 | 357 | 358 | 359 | 360 | 361 | 362 | 363 | 364 | 365 | 366 | 367 | 368 | 369 | 370 | 371 | 372 | 373 | 374 | 375 | 376 | 377 | 378 | 379 | 380 | 381 | 382 | 383 | 384 | 385 | 386 | 387 | 388 | 389 | 390 | 391 | 392 | 393 | 394 | 395 | 396 | 397 | 398 | 399 | 400 | 401 | 402 | 403 | 404 | 405 | 406 | 407 | 408 | 409 | 410 | 411 | 412 | 413 | 414 | 415 | 416 | 417 | 418 | 419 | 420 | 421 | 422 | 423 | 424 | 425 | 426 | 427 | 428 | 429 | 430 | 431 | 432 | 433 | 434 | 435 | 436 | 437 | 438 | 439 | 440 | 441 | 442 | 443 | 444 | 445 | 446 | 447 | 448 | 449 | 450 | 451 | 452 | 453 | 454 | 455 | 456 | 457 | 458 | 459 | 460 | 461 | 462 | 463 | 464 | 465 | 466 | 467 | 468 | 469 | 470 | 471 | 472 | 473 | 474 | 475 | 476 | 477 | 478 | 479 | 480 | 481 | 482 | 483 | 484 | 485 | 486 | 487 | 488 | 489 | 490 | 491 | 492 | 493 | 494 | 495 | 496 | 497 | 498 | 499 | 500 | 501 | 502 | 503 | 504 | 505 | 506 | 507 | 508 | 509 | 510 | 511 | 512 | 513 | 514 | 515 | 516 | 517 | 518 | 519 | 520 | 521 | 522 | 523 | 524 | 525 | 526 | 527 | 528 | 529 | 530 | 531 | 532 | 533 | 534 | 535 | 536 | 537 | 538 | 539 | 540 | 541 | 542 | 543 | 544 | 545 | 546 | 547 | 548 | 549 | 550 | 551 | 552 | 553 | 554 | 555 | 556 | 557 | 558 | 559 | 560 | 561 | 562 | 563 | 564 | 565 | 566 | 567 | 568 | 569 | 570 | 571 | 572 | 573 | 574 | 575 | 576 | 577 | 578 | 579 | 580 | 581 | 582 | 583 | 584 | 585 | 586 | 587 | 588 | 589 | 590 | 591 | 592 | 593 | 594 | 595 | 596 | 597 | 598 | 599 | 600 | 601 | 602 | 603 | 604 | 605 | 606 | 607 | 608 | 609 | 610 | 611 | 612 | 613 | 614 | 615 | 616 | 617 | 618 | 619 | 620 | 621 | 622 | 623 | 624 | 625 | 626 | 627 | 628 | 629 | 630 | 631 | 632 | 633 | 634 | 635 | 636 | 637 | 638 | 639 | 640 | 641 | 642 | 643 | 644 | 645 | 646 | 647 | 648 | 649 | 650 | 651 | 652 | 653 | 654 | 655 | 656 | 657 | 658 | 659 | 660 | 661 | 662 | 663 | 664 | 665 | 666 | 667 | 668 | 669 | 670 | 671 | 672 | 673 | 674 | 675 | 676 | 677 | 678 | 679 | 680 | 681 | 682 | 683 | 684 | 685 | 686 | 687 | 688 | 689 | 690 | 691 | 692 | 693 | 694 | 695 | 696 | 697 | 698 | 699 | 700 | 701 | 702 | 703 | 704 | 705 | 706 | 707 | 708 | 709 | 710 | 711 | 712 | 713 | 714 | 715 | 716 | 717 | 718 | 719 | 720 | 721 | 722 | 723 | 724 | 725 | 726 | 727 | 728 | 729 | 730 | 731 | 732 | 733 | 734 | 735 | 736 | 737 | 738 | 739 | 740 | 741 | 742 | 743 | 744 | 745 | 746 | 747 | 748 | 749 | 750 | 751 | 752 | 753 | 754 | 755 | 756 | 757 | 758 | 759 | 760 | 761 | 762 | 763 | 764 | 765 | 766 | 767 | 768 | 769 | 770 | 771 | 772 | 773 | 774 | 775 | 776 | 777 | 778 | 779 | 780 | 781 | 782 | 783 | 784 | 785 | 786 | 787 | 788 | 789 | 790 | 791 | 792 | 793 | 794 | 795 | 796 | 797 | 798 | 799 | 800 | 801 | 802 | 803 | 804 | 805 | 806 | 807 | 808 | 809 | 810 | 811 | 812 | 813 | 814 | 815 | 816 | 817 | 818 | 819 | 820 | 821 | 822 | 823 | 824 | 825 | 826 | 827 | 828 | 829 | 830 | 831 | 832 | 833 | 834 | 835 | 836 | 837 | 838 | 839 | 840 | 841 | 842 | 843 | 844 | 845 | 846 | 847 | 848 | 849 | 850 | 851 | 852 | 853 | 854 | 855 | 856 | 857 | 858 | 859 | 860 | 861 | 862 | 863 | 864 | 865 | 866 | 867 | 868 | 869 | 870 | 871 | 872 | 873 | 874 | 875 | 876 | 877 | 878 | 879 | 880 | 881 | 882 | 883 | 884 | 885 | 886 | 887 | 888 | 889 | 890 | 891 | 892 | 893 | 894 | 895 | 896 | 897 | 898 | 899 | 900 | 901 | 902 | 903 | 904 | 905 | 906 | 907 | 908 | 909 | 910 | 911 | 912 | 913 | 914 | 915 | 916 | 917 | 918 | 919 | 920 | 921 | 922 | 923 | 924 | 925 | 926 | 927 | 928 | 929 | 930 | 931 | 932 | 933 | 934 | 935 | 936 | 937 | 938 | 939 | 940 | 941 | 942 | 943 | 944 | 945 | 946 | 947 | 948 | 949 | 950 | 951 | 952 | 953 | 954 | 955 | 956 | 957 | 958 | 959 | 960 | 961 | 962 | 963 | 964 | 965 | 966 | 967 | 968 | 969 | 970 | 971 | 972 | 973 | 974 | 975 | 976 | 977 | 978 | 979 | 980 | 981 | 982 | 983 | 984 | 985 | 986 | 987 | 988 | 989 | 990 | 991 | 992 | 993 | 994 | 995 | 996 | 997 | 998 | 999 | 1000 | 1001 | 1002 | 1003 | 1004 | 1005 | 1006 | 1007 | 1008 | 1009 | 1010 | 1011 | 1012 | 1013 | 1014 | 1015 | 1016 | 1017 | 1018 | 1019 | 1020 | 1021 | 1022 | 1023 | 1024 | 1025 | 1026 | 1027 | 1028 | 1029 | 1030 | 1031 | 1032 | 1033 | 1034 | 1035 | 1036 | 1037 | 1038 | 1039 | 1040 | 1041 | 1042 | 1043 | 1044 | 1045 | 1046 | 1047 | 1048 | 1049 | 1050 | 1051 | 1052 | 1053 | 1054 | 1055 | 1056 | 1057 | 1058 | 1059 | 1060 | 1061 | 1062 | 1063 | 1064 | 1065 | 1066 | 1067 | 1068 | 1069 | 1070 | 1071 | 1072 | 1073 | 1074 | 1075 | 1076 | 1077 | 1078 | 1079 | 1080 | 1081 | 1082 | 1083 | 1084 | 1085 | 1086 | 1087 | 1088 | 1089 | 1090 | 1091 | 1092 | 1093 | 1094 | 1095 | 1096 | 1097 | 1098 | 1099 | 1100 | 1101 | 1102 | 1103 | 1104 | 1105 | 1106 | 1107 | 1108 | 1109 | 1110 | 1111 | 1112 | 1113 | 1114 | 1115 | 1116 | 1117 | 1118 | 1119 | 1120 | 1121 | 1122 | 1123 | 1124 | 1125 | 1126 | 1127 | 1128 | 1129 | 1130 | 1131 | 1132 | 1133 | 1134 | 1135 | 1136 | 1137 | 1138 | 1139 | 1140 | 1141 | 1142 | 1143 | 1144 | 1145 | 1146 | 1147 | 1148 | 1149 | 1150 | 1151 | 1152 | 1153 | 1154 | 1155 | 1156 | 1157 | 1158 | 1159 | 1160 | 1161 | 1162 | 1163 | 1164 | 1165 | 1166 | 1167 | 1168 | 1169 | 1170 | 1171 | 1172 | 1173 | 1174 | 1175 | 1176 | 1177 | 1178 | 1179 | 1180 | 1181 | 1182 | 1183 | 1184 | 1185 | 1186 | 1187 | 1188 | 1189 | 1190 | 1191 | 1192 | 1193 | 1194 | 1195 | 1196 | 1197 | 1198 | 1199 | 1200 | 1201 | 1202 | 1203 | 1204 | 1205 | 1206 | 1207 | 1208 | 1209 | 1210 | 1211 | 1212 | 1213 | 1214 | 1215 | 1216 | 1217 | 1218 | 1219 | 1220 | 1221 | 1222 | 1223 | 1224 | 1225 | 1226 | 1227 | 1228 | 1229 | 1230 | 1231 | 1232 | 1233 | 1234 | 1235 | 1236 | 1237 | 1238 | 1239 | 1240 | 1241 | 1242 | 1243 | 1244 | 1245 | 1246 | 1247 | 1248 | 1249 | 1250 | 1251 | 1252 | 1253 | 1254 | 1255 | 1256 | 1257 | 1258 | 1259 | 1260 | 1261 | 1262 | 1263 | 1264 | 1265 | 1266 | 1267 | 1268 | 1269 | 1270 | 1271 | 1272 | 1273 | 1274 | 1275 | 1276 | 1277 | 1278 | 1279 | 1280 | 1281 | 1282 | 1283 | 1284 | 1285 | 1286 | 1287 | 1288 | 1289 | 1290 | 1291 | 1292 | 1293 | 1294 | 1295 | 1296 | 1297 | 1298 | 1299 | 1300 | 1301 | 1302 | 1303 | 1304 | 1305 | 1306 | 1307 | 1308 | 1309 | 1310 | 1311 | 1312 | 1313 | 1314 | 1315 | 1316 | 1317 | 1318 | 1319 | 1320 | 1321 | 1322 | 1323 | 1324 | 1325 | 1326 | 1327 | 1328 | 1329 | 1330 | 1331 | 1332 | 1333 | 1334 | 1335 | 1336 | 1337 | 1338 | 1339 | 1340 | 1341 | 1342 | 1343 | 1344 | 1345 | 1346 | 1347 | 1348 | 1349 | 1350 | 1351 | 1352 | 1353 | 1354 | 1355 | 1356 | 1357 | 1358 | 1359 | 1360 | 1361 | 1362 | 1363 | 1364 | 1365 | 1366 | 1367 | 1368 | 1369 | 1370 | 1371 | 1372 | 1373 | 1374 | 1375 | 1376 | 1377 | 1378 | 1379 | 1380 | 1381 | 1382 | 1383 | 1384 | 1385 | 1386 | 1387 | 1388 | 1389 | 1390 | 1391 | 1392 | 1393 | 1394 | 1395 | 1396 | 1397 | 1398 | 1399 | 1400 | 1401 | 1402 | 1403 | 1404 | 1405 | 1406 | 1407 | 1408 | 1409 | 1410 | 1411 | 1412 | 1413 | 1414 | 1415 | 1416 | 1417 | 1418 | 1419 | 1420 | 1421 | 1422 | 1423 | 1424 | 1425 | 1426 | 1427 | 1428 | 1429 | 1430 | 1431 | 1432 | 1433 | 1434 | 1435 | 1436 | 1437 | 1438 | 1439 | 1440 | 1441 | 1442 | 1443 | 1444 | 1445 | 1446 | 1447 | 1448 | 1449 | 1450 | 1451 | 1452 | 1453 | 1454 | 1455 | 1456 | 1457 | 1458 | 1459 | 1460 | 1461 | 1462 | 1463 | 1464 | 1465 | 1466 | 1467 | 1468 | 1469 | 1470 | 1471 | 1472 | 1473 | 1474 | 1475 | 1476 | 1477 | 1478 | 1479 | 1480 | 1481 | 1482 | 1483 | 1484 | 1485 | 1486 | 1487 | 1488 | 1489 | 1490 | 1491 | 1492 | 1493 | 1494 | 1495 | 149 |
|---|---|---|---|---|---|---|---|---|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 1 0 6

1- FOR  
STATE  
REGISTRAR

REG. NO.

|   |  |  |  |   |  |   |  |  |  |
|---|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br><b>HELEN DELORES SZUBA</b> |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4 11 83</b> |   |  | 2b. HOUR <sup>~</sup><br><b>100 A M</b>   |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>Caucasian</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>10 28 01</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>81</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>PENNSYLVANIA</b>                    |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY County MD.</b>                            |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>GAITHERSBURG</b>                                    |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>101 ODENHAL ROAD</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>HOMEMAKER</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>HOME</b>           |  |
| 13a. STATE<br><b>MARYLAND</b>   |  | 13b. COUNTY<br><b>MONTGOMERY</b>   |  | 13c. CITY OR TOWN<br><b>GAITHERSBURG</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>101 ODENHAL ROAD 20877</b>       |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>NOT AVAILABLE</b>                         |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>NOT AVAILABLE</b>  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES OR NO OR UNKNOWN) <b>NO</b>    |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>152-18-4008</b>  |  | 17. INFORMANT<br><b>JOAN C. KASPRZAK</b>  |  | 17a. ADDRESS<br><b>1285 BARTONSHIRE WAY</b>   |  | 17b. CITY OR TOWN<br><b>ROCKVILLE, MARYLAND 20854</b>      |  |

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**Heart Attack**APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**Immediate**

4100  
Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Coronary artery disease****20 yrs**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**none**

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>      |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>5/28</b> , 19 <b>82</b> , to <b>9/11</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/7/83</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |   |  |
| 22b. SIGNATURE<br><b>Michael A. Greene</b>   |  | DEGREE<br><b>M.D.</b>  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4/12/83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Michael A. Greene</b>  |  | M.D.   |  | 22e. ADDRESS<br><b>19271 Montgomery Village Ave Gaithersburg MD</b>  |  |   |  |

|  |  |                                    |  |   |  |  |  |
|--|--|------------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>CREMATION</b> |  | 23b. DATE<br><b>APRIL 13, 1983</b> |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Metropolitan Crematory Alexandria Fairfax Virginia</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE       |  |
| 24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b>                   |  |                                    |  | FUNERAL HOMES P/A <b>300 W. MONTGOMERY AVE., ROCKVILLE, MD. 20850</b>                           |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 21 1983</b> |  |
|  |  |                                    |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Casper</b>   |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



Item #1 Film G579 5/16/83 rc

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                            |  |  |   |
|---|----------------------------|--|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Miki Takahashi</b>  |                            | 2a. DATE KNOWN OF DEATH<br><input checked="" type="checkbox"/> MONTH DAY YEAR<br><b>4-27-1983</b>                                      |  | 2b. HOUR<br><b>10:35</b>  |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Oriental</b> | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>4 22 82</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>YRS.<br><b>1</b>        | 7. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br><b>4-27-1983</b>   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>  |                            | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>  |                            | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Suburban Hospital</b> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b>  |
| 12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |                            |  |  |   |
| 12b. KIND OF BUSINESS OR INDUSTRY   |                            |  |  |   |
| 13a. STATE<br><b>Maryland</b>   |                            | 13b. COUNTY<br><b>Montgomery</b>   | 13c. CITY OR TOWN<br><b>Rockville</b>                      | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Kazuyuki Takahashi</b>   |                            | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Keiko Maezata</b>  |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br><b>No</b>  |                            | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS<br><b>Mace Miyasaki 3324 Gilman Terrace 21211</b>   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Incised Wound of chest</b><br>9660<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). |                            |  |  |   |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                            |  |  |   |
| 19a. DATE OF OPERATION  |                            | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                            | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>9:15 AM 4-27-1983</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>subject was stabbed</b>   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/><br>AT WORK AT WORK  |                            | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>home</b>   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>1001 Rockville Pike, Rockville, Montg., Co., Md.</b>  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .  |                            |  |  |   |
| ACTUAL SIGNATURE<br><i>Dennis F. Smyth M.D.</i>   |                            | TITLE (SPECIFY):<br><b>Assistant</b>   |  | DATE SIGNED<br><b>4-27-83</b>   |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br><b>Dennis F. Smyth, M.D.</b>  |                            | ADDRESS<br><b>111 Penn Street, Baltimore, Md.</b>  |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                            | 23b. DATE<br><b>5/3/83</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b> | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Baltimore Maryland</b>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>A. Alan Seitz, Jr.</b>   |                            | ADDRESS<br><b>3818 Roland Avenue 21211</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 5 1983</b>  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |  | 8 3 1 1 1 0 8   |  |
|---|--|--|--|---|--|
| 1 - STATE REGISTRAR   |  |  |  | CERTIFICATE OF DEATH  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |
| FIRST Bessie MIDDLE C. LAST Tatum<br>BESSIE C. TATUM  |  |  |  | April 14 1983 10 <sup>28</sup> P M  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH MONTH DAY YEAR   |  |
| Female  |  | White  |  | Jan - 28 - 1890   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                              |  |
| North Carolina  |  | USA  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD   |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)   |  |
| WHEATON   |  | MANOR CARE WHEATON   |  | Gov. CLERK  |  |
| 12b. KIND OF BUSINESS OR INDUSTRY   |  | 13a. STREET ADDRESS  |  | 13b. CITY OR TOWN   |  |
| US Gov't.   |  | 3133 Connecticut Ave., N.W.  |  | Washington  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |
| Joseph Carson   |  | Martha Quillman  |  | No  |  |
| 16b. SOCIAL SECURITY NO.  |  | 17. INFORMANT ADDRESS  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 CARDIAC ARREST   |  |
| Unknown   |  | Martha Payne, 169 Hurlbutt St, Wilton, Conn.   |  | DUE TO, OR AS A CONSEQUENCE OF (b) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE 5 YEARS   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19  |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  | 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  | 22a. I certify that (I) (this hospital) attended the deceased from 7/1 19 79, to 4/14 19 83, that (I) (we) last saw the deceased alive on 4/12 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  | 22b. SIGNATURE DEGREE Kevin G. Nealon M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |
| 22c. DATE SIGNED 4/14/83  |  | 22d. PHYSICIAN'S NAME (TYPE OR PRINT) KEVIN G. NEALON M.D.   |  | 22e. ADDRESS 916 19th ST. N.W. WASH. D.C. 20006   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial  |  | 23b. DATE 4/18/83  |  | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery  |  |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland   |  | 24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME ADDRESS 5130 Wisconsin Ave., NW, Washington, D.C. 20016   |  | 25a. DATE REC'D. BY REGISTRAR APR 20 1983 REGISTRAR'S SIGNATURE John J. Gawler  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. 8311109  |  |   |  |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR   |  |   |  |
| 1. DECEASED NAME FIRST MIDDLE LAST GORDON Russell Tatum<br>GORDON RUSSELL TATUM  |  |  |  | April 5, 1983 10:20 AM  |  |   |  |
| 2. SEX Male  |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 30, 1904   |  | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Texas  |  | 7b. CITIZEN OF WHAT COUNTRY? USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |
| 10. CITY OR TOWN OF DEATH BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN Hospital |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Executive   |  | 12b. KIND OF BUSINESS OR INDUSTRY Electronics   |  |
| 13a. STATE Md. 20815 13b. COUNTY Montgomery 13c. CITY OR TOWN Chevy Chase  |  |  |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS 3902 Rosemary Street 20815  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST John Marvin Tatum  |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linna Tindel   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 217-28-8633   |  | 17. INFORMANT ADDRESS Mary E. Tatum, Same address as #13.   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140 Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years |  |  |  |   |  |   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Chronic Obstructive Pulmonary Disease  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION None  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |   |  |
| 22a. I certify that (I) (This hospital) attended the deceased from 3/31, 19 83, to 4/5, 19 83, that (I) (we) lost saw the deceased alive on 4/5, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (decelat) view the body after death.   |  |  |  |   |  |   |  |
| 22b. SIGNATURE Joel Schalmor   |  |  |  | DEGREE ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> |  | 22c. DATE SIGNED 4/5/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schalmor  |  |  |  | 22e. ADDRESS 9410 Old Georgetown Road Bethesda  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation  |  | 23b. DATE 4/7/83   |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland, Maryland  |  |
| 24. FUNERAL DIRECTOR NAME Joseph Gawler's Sons, Inc. ADDRESS 5130 Wisconsin Ave., NW, Washington, D.C. 20016   |  |  |  | 25a. DATE REC'D. BY REGISTRAR 25. REGISTRAR'S SIGNATURE APR 12 1983 John J. Canale  |  |   |  |

UNITED STATES DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF MEDICAL SERVICE  
WASHINGTON, D. C.

REPORT OF MEDICAL EXAMINATION

NAME: \_\_\_\_\_

AGE: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

PLACE: \_\_\_\_\_

BY: \_\_\_\_\_

DATE: \_\_\_\_\_

TIME: \_\_\_\_\_

EXAMINER: \_\_\_\_\_

REPORT: \_\_\_\_\_

DATE: \_\_\_\_\_

BY: \_\_\_\_\_

PLACE: \_\_\_\_\_

TIME: \_\_\_\_\_

NAME: \_\_\_\_\_

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DATE: \_\_\_\_\_

BY: \_\_\_\_\_

DATE: \_\_\_\_\_

PLACE: \_\_\_\_\_

APR 1 1954

WASHINGTON, D. C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR   |  |  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | REG. NO. 8311110   |  |   |  |
|--|--|--|--|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT)<br>JOSEPH E. THOMPSON, Jr.  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>APRIL 28 1983   |  |   |  | 2b. HOUR<br>10:10 P <sub>M</sub>   |  |   |  |
| 3. SEX<br>MALE   |  | 4. RACE<br>CAUCASIAN   |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>OCTOBER 6 1915   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>67 YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  | IF UNDER 24 HRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>ALABAMA   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NAVAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                        |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S.N.  |  |   |  |
| 13a. STATE<br>VIRGINIA   |  | 13b. COUNTY<br>FAIRFAX   |  | 13c. CITY OR TOWN<br>ALEXANDRIA   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 13e. STREET ADDRESS<br>4929 TUNLAW STREET 22312  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>JOSEPH ERNEST THOMPSON, Sr.   |  |  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MAY OLIVE ARNOLD  |  |   |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>YES   |  | 16b. SOCIAL SECURITY NO.<br>1941-1966  |  | 16c. DATE OF DEATH<br>1941-1966   |  | 16d. SOCIAL SECURITY NO.<br>113-01-2937   |  | 16e. INFORMANT ADDRESS<br>Wife- CRYSTAL T. THOMPSON, 4929 TUNLAW STREET  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>2028 IMMEDIATE CAUSE (a) LARGE CELL LYMPHOMA<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____  |  |  |  |   |  |   |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |  |  |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from APRIL 19 83, to APRIL 28 83, that (I) (we) last saw the deceased alive on APRIL 28 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.                                       |  |  |  |   |  |   |  |  |  |   |  |
| 22b. SIGNATURE<br>R. L. Sollock LCDR, MC, USN  |  |  |  | DEGREE<br>M.D.  |  |   |  | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> |  | 22c. DATE SIGNED<br>29 APR 83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>R. L. SOLLOCK, LCDR, MC, USN  |  |  |  | 22e. ADDRESS<br>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814  |  |   |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>May 3, 1983   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National Cemetery   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Arlington Va.  |  |  |  |   |  |
| 24. FUNERAL DIRECTOR NAME<br>Demaine Funeral Homes, Inc., Alex., Va 22314  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAY 3 1983   |  | 25b. REGISTRAR'S SIGNATURE<br>J. L. L...  |  |  |  |   |  |



[Faint, mostly illegible text covering the main body of the page, appearing to be a memorandum or report.]

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR  
STATE  
REGISTRARSTATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 1 1 1

REG. NO.

|   |  |   |  |   |  |  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Alexander NMN Tokoli</b>  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4 1 83</b> |   |  | 2b. HOUR<br><b>1000AM</b>  |  |  |  |
| 3. SEX<br><b>Male</b>   |  | 4. RACE<br><b>White</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>June 3, 1917</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>65</b> YRS.  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Hungary</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Kensington</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>11110 Stillwater Avenue</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Machinist-retired</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |
| 13a. STATE<br><b>Maryland</b>   |  | 13b. COUNTY<br><b>Montgomery</b>  |  | 13c. CITY OR TOWN<br><b>Kensington</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |  | 13e. STREET ADDRESS<br><b>11110 Stillwater Avenue</b>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Miklos Tokoli</b>  |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Jozan Liddie</b>  |  |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>No</b>   |  | 16b. SOCIAL SECURITY NO.<br><b>291-36-3192</b>  |  | 17. INFORMANT<br><b>Tamas Tokoli</b>  |  | ADDRESS<br><b>6602 Pebble Court, Frederick, Md.</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Adenocarcinoma of the Colon (1979)</b><br><b>1539</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>4-1-83</b> |  |   |  |   |  |  |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):  |  |   |  |   |  |  |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 10</b> , 19 <b>83</b> , to <b>April 1</b> , 19 <b>83</b> , that I (we) lost saw the deceased alive on <b>March 31</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |  |   |  |  |  |  |  |
| 22b. SIGNATURE<br><b>Richard W. Holt</b> DEGREE   |  |   |  |   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br><b>4-1-83</b>  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Richard W. Holt, M.D.</b>   |  |   |  | 22e. ADDRESS<br><b>3800 Reservoir Rd., N.W. Washington, D.C. 2000</b>   |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>4/4/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Memorial Park</b>   |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Rockville, Maryland</b> |  |  |
| 24. FUNERAL DIRECTOR<br><b>Tyson Wheeler Funeral Home, Inc.</b><br><b>1331 Rockville Pike Rockville, Maryland 20852</b>   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 6 1983</b>  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>  |  |  |  |

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STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

8311112

 FOR  
 1- STATE  
 REGISTRAR

REG. NO.

|  |  |   |  |  |  |
|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>LAURENCE</b><br><del>XXXXXXXXXX</del> <b>Marshall Torreyson</b>                                  |  | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4-30-83</b>  |  | 2b. HOUR<br><b>2:10 A.M.</b>   |  |
| 3. SEX<br><b>MALE</b>  |  | 4. RACE<br><b>CAUCASIAN</b>   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>SEPT 13, 1916</b>   |  |
| 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>66</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>66</b>   |  | IF UNDER 24 HRS.<br>HOURS MIN.<br><b>66</b>  |  |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>WASHINGTON D.C.</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |
| 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.  |  | 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WASHINGTON ADVENTIST HOSPITAL</b>  |  |
| 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>OUTRIDER</b>  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>AUREL RACE TRACK</b>  |  | 13a. STREET ADDRESS<br><b>2419 ECCLESTON STREET</b>  |  |
| 13b. STATE<br><b>MARYLAND</b>  |  | 13c. CITY OR TOWN<br><b>SILVER SPRING</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>LOUIS ELMORE TORREYSON</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>ELLA V. BATES</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE YEAR OR DATES)<br><b>YES WW II</b>  |  |
| 16b. SOCIAL SECURITY NO.<br><b>217-14-7292</b>   |  | 17. INFORMANT<br>ADDRESS<br><b>GRACE LUCILLE TORREYSON SAME AS 13 WIFE</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br><b>1991</b> IMMEDIATE CAUSE (a) <b>METASTATIC SQUAMOUS CELL CARCINOMA</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) _____<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>18 MOS.</b> |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____ |  |   |  |  |  |
| 19a. DATE OF OPERATION<br><b>—</b>   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>—</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>                 |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>—</b> P.M. <b>19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)<br><b>—</b>   |  | 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)<br><b>—</b>   |  |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>—</b>  |  | 22a. I certify that (I) (this hospital) attended the deceased from <b>SPRING</b> , 19 <b>82</b> , to <b>4/30</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/29</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) did not touch the body after death. |  | 22b. SIGNATURE<br><b>Arnold G. Levy, MD</b>  |  |
| 22c. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>ARNOLD G. LEVY, MD</b>   |  | 22d. ADDRESS<br><b>1106 SPRING ST.<br/>SILVER SPRING, MD. 20910</b>   |  | 22e. DATE SIGNED<br><b>4/30/83</b>   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>5/3/83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKLAWN CEMETERY</b>   |  |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROCKVILLE MONT MD.</b>  |  | 24. FUNERAL DIRECTOR<br>NAME<br><b>FRANCIS J. COLLINS</b>   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 6 1983</b>   |  |
| 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canfield</b>  |  |   |  |  |  |

 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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MEDICAL CERTIFICATION

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CHARTERED BY THE  
UNITED STATES GOVERNMENT  
OFFICE OF THE SECRETARY OF THE ARMY  
WASHINGTON, D. C.



MADE BY  
UNITED STATES GOVERNMENT

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
15M 2/80

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |  |  |  |  |  |  |  |  | REG. NO. 11113  |  |
|--|--|--|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR   |  |  |  |  |  |  |  |  |  | 7a. DATE KNOWN OF DEATH   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Kenneth Gerald Tower</b>   |  |  |  |  |  |  |  |  |  | 7b. DATE ESTIMATED <b>4 3 83</b>  |  |
| 3. SEX <b>Male</b> 4. RACE <b>Cauca.</b> 5. DATE OF BIRTH <b>Feb. 10, 1910</b> 6. AGE (IN YEARS) <b>73</b> YRS.  |  |  |  |  |  |  |  |  |  | 7c. DATE PRONOUNCED DEAD <b>4. 3 83</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b> 7b. CITIZEN OF WHAT COUNTRY? <b>United States</b> 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b>  |  |
| 10. CITY OR TOWN OF DEATH <b>Rockville</b> 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Shady Grove Adventist Hospital</b>   |  |  |  |  |  |  |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Civil Engineer</b>                 |  |
| 12b. KIND OF BUSINESS OR INDUSTRY <b>US Gov't</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Montgomery</b> 13c. CITY OR TOWN <b>Rockville</b>  |  |  |  |  |  |  |  |  |  | 13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 13e. STREET ADDRESS <b>609 Blossom Drive 20850</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 14. FATHER'S NAME <b>Harry B. Tower</b> 15. MOTHER'S MAIDEN NAME <b>Cora Ward</b>  |  |  |  |  |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>543 24 2357</b> 17. INFORMANT <b>wife 609 Blossom Drive</b>   |  |  |  |  |  |  |  |  |  | 17. INFORMANT <b>Jean H. Tower Rockville, Maryland</b>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1 DEATH WAS CAUSED BY:<br><b>4100</b> IMMEDIATE CAUSE (a) <b>cardiac arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>coronary thrombosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)  |  |  |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>chronic alcoholism</b>   |  |  |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  |  |  |  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |  |  |  |  |  |  |  |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |  |  |  |  |  |  |  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)  |  |  |  |  |  |  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  |  |  |  |  |  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John Tauber</b> M.D. TITLE (SPECIFY) <b>8218 was concin se</b>   |  |  |  |  |  |  |  |  |  | DATE SIGNED <b>4-3-83</b>   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John Tauber</b> ADDRESS   |  |  |  |  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b> 23b. DATE <b>April 7, 1983</b> 23c. NAME OF CEMETERY OR CREMATORY <b>Metropolitan Crematory</b>   |  |  |  |  |  |  |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Alexandria, Virginia</b>                                 |  |
| 24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY</b> NAME <b>HOMES, P.A., ROCKVILLE, MARYLAND</b> ADDRESS  |  |  |  |  |  |  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 15 1983</b> 25b. REGISTRAR'S SIGNATURE <b>John J. Smith</b>    |  |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |  |   | 8 3 1 1 1 1 4  |   |
|---|--|--|---|--|---|
| 1- FOR STATE REGISTRAR  |  |  |   | REG. NO.   |   |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Louie S. Toy</b>   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 27, 1983</b><br>2b. HOUR<br><b>8 P.M.</b>       |  |   |
| 3. SEX<br><b>Female</b>   | 4. RACE<br><b>Oriental</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 24 1911</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>71</b><br>IF UNDER 1 YEAR: MONTHS DAYS HOURS MIN.<br>YRS. |  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>China</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>      | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD.                            |  |   |
| 10. CITY OR TOWN OF DEATH<br><b>Silver Spring</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>2208, Touchstone Court, S.S.</b> |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>At home</b>   |
| 13a. STATE<br><b>Maryland</b>   |  |  | 13b. COUNTY<br><b>Montgomery</b>  | 13c. CITY OR TOWN<br><b>Silver Spring</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Shih H. Louie</b>  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Unknown Tsal</b>                            |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>577663210</b>  | 17. INFORMANT (Son)<br>ADDRESS<br><b>Victor Toy, 2208, Touchstone Ct. S.S. Md.</b>              |  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>extensive intraperitoneal carcinomatosis</b><br><b>1561</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of bile duct of left lobe of liver</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one year</b>                                 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |  |  |   |  |   |
| 19a. DATE OF OPERATION<br><b>Feb. 25, 1982</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Fibrotic infected left lobe of liver</b>  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  | 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)         |   |  |   |
| 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |   |  |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |   |  |   |
| 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |   |  |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>3/28/83</b> , 19 <b>58</b> , to <b>4/27/83</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>4/27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |  |   |  |   |
| 22b. SIGNATURE<br><b>Hsiang Len Tseng</b>   |  | DEGREE<br><b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br><b>1983 April 27, 15</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Hsiang Len Tseng, M.D.</b>  |  | 22e. ADDRESS<br><b>1211, LaGrande Road, Silver Spring, Md. 20903</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>May 1, 1983</b>  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>George Washington Cem.</b>                             |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Adelphi, Prince George, MD.</b>                |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>J. William Lee's Sons Co.</b>  |  | ADDRESS<br><b>300-4th St., NE, Wash., DC</b>   |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 3 1983</b>                                   |   |
|   |  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>                                  |   |



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination must be held and a report filed.

## MEDICAL CERTIFICATION

| FOR STATE REGISTRAR   |  |   |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | 8 3 1 1 1 1 5<br>REG. NO.  |  |  |  |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Margaret D. Tressler   |  |   |  | 2a. DATE OF DEATH<br>April 13 1983  |  |  |  | 2b. HOUR<br>3 A.M.   |  |  |  |
| 3. SEX<br>Female  |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH<br>June 23 1925  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>57 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS   |  | IF UNDER 24 HRS.<br>HOURS MIN.               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash. D.C.   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |  |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Wheaton  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>2801 Elnora Street |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife        |  | 12b. KIND OF BUSINESS OR INDUSTRY  |  |  |  |
| 13a. STATE<br>Md.   |  | 13b. COUNTY<br>Mont.  |  | 13c. CITY OR TOWN<br>Wheaton  |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>2801 Elnora Street 20902  |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Francis Davis   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lula Pounds  |  |  |  | 16. ADDRESS<br>1302 Thurston Rd. Dickerson, Md.  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br>None  |  | 16b. SOCIAL SECURITY NO.<br>218 20 0780   |  | 17. INFORMANT<br>Hammond H. Tressler (Son)  |  | 20842  |  |  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1539 IMMEDIATE CAUSE (a) Metastatic carcinoma<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) Carcinoma of Colon<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. |  |   |  |   |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a<br>None  |  |   |  |   |  |  |  |  |  |  |  |
| 19a. DATE OF OPERATION<br>8/82  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Carcinoma of Colon  |  |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |  |  |  |  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |  |  |  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from April 5 1983, to present 1983, that (I) (we) last saw the deceased alive on April 5 1983, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) did not view the body after death.  |  |   |  |   |  |  |  |  |  |  |  |
| 22b. SIGNATURE<br>John B. Umkhu MR  |  |   |  | DEGREE<br>MR  |  |  |  | 22c. DATE SIGNED<br>4/13/85  |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>John B. Umkhu MD   |  |   |  | 22e. ADDRESS<br>8805 Conn. Ave. Chevy Chase, Md.  |  |  |  |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial   |  | 23b. DATE<br>4/15/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>S.S. Mont. Maryland                    |  |  |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Hines/Rinaldi 11800 N.H. Ave. S.S. Md.  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 14 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>J. J. Carver   |  |  |  |  |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 4/82  
(VRA 15, 4)

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 1 1 6

REG. NO.

1. FOR  
STATE  
REGISTRAR

|   |  |   |   |   |  |   |  |   |  |
|---|--|---|---|---|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Rebecca E Trotter</b>      |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>4-26-83</b> |   |  | 2b. HOUR<br><b>7<sup>21</sup> A.M.</b>  |  |   |  |
| 3. SEX<br><b>Female</b>   |  | 4. RACE<br><b>W</b>   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>6 25 14</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>  |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN. |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MD</b>            |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |   | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery MD.</b>                                   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Silverspring</b>                  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Holy Cross Hospital</b> |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b>            |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>                |  |
| 13a. STATE<br><b>Wash. DC</b>                                     |  | 13b. COUNTY<br><b>MD</b>  |   | 13c. CITY OR TOWN<br><b>Wash. DC</b>  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>803 Aspen St. N.W.</b>                |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Jessie Nicholson</b> |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Mary Hughes</b>   |   | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  |   |  |   |  |
| 16b. SOCIAL SECURITY NO.<br><b>577-01-2317</b>                    |  | 17. INFORMANT<br><b>Richard H. Trotter, Husband, Same as item #13</b>   |   |   |  |   |  |   |  |

|   |  |  |  |
|---|--|--|--|
| 18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>1539</b> IMMEDIATE CAUSE (a) <b>metastatic Ca, colon primary</b> |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 mo</b> |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____   |  |  |  |
| DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |  |  |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from<br>saw the deceased alive on <b>4-25-83</b> , and that in (my) <b>best</b> opinion death occurred on the date and hour and from the causes stated<br>above. (I) <b>did not</b> view the body after death. |  | 22b. SIGNATURE<br><b>George F. Sengstack M.D.</b>                      |  | 22c. DATE SIGNED<br><b>4-26-83</b>   |  |   |  |

|  |  |   |  |   |  |  |  |
|--|--|---|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY) <b>Burial</b> |  | 23b. DATE<br><b>April 28, 1983</b>                        |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood, Maryland</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>Robert A. Pumphrey</b>  |  | ADDRESS<br><b>Funeral Homes, P.A., Bethesda, Maryland</b> |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 2 1983</b>                |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Cabell</b>                      |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE  |  |   |   | 8 3 1 1 1 1 7  |  |
|---|--|---|---|--|--|
| FOR<br>1 - STATE<br>REGISTRAR   |  |   |   | REG. NO.   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>ANNA REBECCA TROXELL</b>   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>APRIL 5, 1983</b>                                     |  | 2b. HOUR<br><b>10:00 AM</b>  |
| 3. SEX<br><b>FEMALE</b>   | 4. RACE<br><b>CAUCASIAN</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>July 30, 1896</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS.<br>HOURS MIN.   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Carroll Co. Md.</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD.</b>                          |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>National Lutheran Home</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Seamstress</b>           | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Greis Clothing Co.</b>                                 |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>STATE COUNTY<br><b>Maryland Carroll Co. Westminister</b>  |  |   | 13b. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13c. STREET ADDRESS<br><b>652 Pennsylvania Ave. 21157</b>                                      |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Frank Nusbaum</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida McKinney</b>  |   |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>no</b>   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br><b>216-10-0517</b>   |   | 17. INFORMANT<br>ADDRESS<br><b>Rev. Richard Reichard 9701 Veirs Dr. Rockville Md.</b>          |  |
| 18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Left lower lobe pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) <b>4860</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)   |  |   |   |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                 |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Oct. 6, 1972</b> to <b>April 5, 1983</b> , that (I) (we) lost<br>saw the deceased die on <b>April 5, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) said and did not view the body after death.              |  |   |   |  |  |
| 22b. SIGNATURE<br><b>Thomas E. Dooley MD</b>  |  | DEGREE  |   | 22c. DATE SIGNED<br><b>April 5, 1983</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Thomas E. Dooley, M.D.</b>  |  | 22e. ADDRESS<br><b>2901 Olney-Sandy Springs Rd. Olney, Maryland</b>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>   |  | 23b. DATE<br><b>April 7, 1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>St. Benj's Lutheran Church Cem. Westminister, Md.</b> |  |
| 24. FUNERAL DIRECTOR<br>NAME<br><b>The Hysong Company</b>   |  | ADDRESS<br><b>1300 N St. N.W. Washington, D.C.</b>  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 11 1983</b>  |  |
|   |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. [Signature]</b>                                       |  |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in accordance with the law, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |   |   |   | 8 3 1 1 1 1 8<br>REG. NO.   |   |
|--|---|---|---|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Stanley Carlin Underwood</b>   |   |   | 2a. DATE OF DEATH <b>April 11, 1983</b> HOUR <b>4-11-83</b> MIN <b>1:32</b> P.M.      |   |   |
| 3. SEX<br><b>Male</b>  | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br><b>Aug. 2, 1914</b> YEAR  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>68</b>  |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN)<br><b>Virginia</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD                                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Takoma Park</b>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Washington Adventist Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Cab Driver</b> |   | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Blue Bird</b> |
| 13a. STATE<br><b>Maryland</b>  |   | 13b. COUNTY<br><b>Prince Geo. Mt.</b>   | 13c. CITY OR TOWN<br><b>Rainier</b>   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Richard H. Underwood</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Ida V. Cornell</b>                |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(IF YES, GIVE WAR OR DATES)<br><b>No</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>222 05 0779</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Susan C. Underwood Same as #13</b>                               |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>1629</b> IMMEDIATE CAUSE (a) <b>insanition</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(b) <b>metastatic lung cancer</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last |   |   |   |   |   |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a   |   |   |   |   |   |
| 19a. DATE OF OPERATION   |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |   |
| 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |   |   |   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)                  |   |
| 21d. INJURY OCCURRED<br>AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (1) this hospital attended the deceased from <b>April 10, 1983</b> to <b>April 11, 1983</b> , that (2) we last saw the deceased alive on <b>April 10, 1983</b> , and that in (my) <b>own</b> opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.                                       |   |   |   |   |   |
| 22b. SIGNATURE<br><b>[Signature]</b>   |   | DEGREE  |   | 22c. DATE SIGNED<br><b>4/11/83</b>  |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>D J HAIDAK MD</b>  |   | 22e. ADDRESS<br><b>6525 Belcrest Road<br/>Hyattsville MD</b>  |   |   |   |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |   | 23b. DATE<br><b>4/15/83</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Ft. Lincoln Cemetery</b>                               |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Brentwood P.G. Maryland</b>   |   |   |   |   |   |
| 24. FUNERAL DIRECTOR<br><b>Francis Gasch's Sons Funeral Home, P.A.<br/>Hyattsville, Md.</b>  |   |   |   | 25. DATE REC'D. BY REGISTRAR<br><b>APR 18 1983</b> REGISTRAR'S SIGNATURE<br><b>[Signature]</b>  |   |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 4/82  
(VRA 15, 4)

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |   |  |  |  |  | 8 3 1 1 1 1 9 |  |
|--|--|--|--|---|---|--|--|--|--|---------------|--|
| 1. FOR<br>STATE<br>REGISTRAR   |  | REG. NO.   |  |   |   |  |  |  |  |               |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Eileen P. Velthaus  |  |  |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April, 16 1983 |  |  | 2b. HOUR<br>8:55a M  |  |               |  |
| 3. SEX<br>Female   |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>3 17 1900   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83  |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |               |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Newfoundland  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD   |  |  |  |               |  |
| 10. CITY OR TOWN OF DEATH<br>Brookville  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>3012 Quail Hollow Terrace |  |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Housewife  |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>Home  |  |               |  |
| 13a. STATE<br>Maryland   |  | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Brookville   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  | 13e. STREET ADDRESS<br>3012 Quail Hollow Terrace 20833   |  |               |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>John O'Brien   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Blackadar   |   |  |  |  |  |               |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES NO OR UNKNOWN)<br>No  |  | 16b. SOCIAL SECURITY NO.<br>110-28-0152  |  | 17. INFORMANT<br>Evelyn Wandell   |   | ADDRESS<br>Same as items 13 a-e  |  |  |  |               |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Metastatic Cancer Colon</u><br>1539<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>8 months</u> |  |  |  |   |   |  |  |  |  |               |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |  |  |   |   |  |  |  |  |               |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)  |   |  |  |  |  |               |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |  |  |  |  |               |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 15</u> , 19 <u>82</u> , to <u>April 16</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>March</u> , 19 <u>1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.   |  |  |  |   |   |  |  |  |  |               |  |
| 22b. SIGNATURE<br><u>[Signature]</u>   |  |  |  | DEGREE<br><u>MD</u>   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/16/83  |  |               |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Lewis Kellert, MD   |  |  |  | 22e. ADDRESS<br>1811 Prince Philip's Dr.<br>Olney, Md. 20832  |   |  |  |  |  |               |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  | 23b. DATE<br>4/20/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>St. Johns Cemetery  |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Queens New York  |  |  |  |               |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Maryland 20852  |  |  |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 20 1983  |   | 25b. REGISTRAR'S SIGNATURE<br><u>[Signature]</u>   |  |  |  |               |  |

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and the body will be autopsied.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |   |  |  |   |  |  | 8311120 |
|---|--|--|--|---|--|--|---|--|--|---------|
| 1. FOR STATE REGISTRAR  |  |  |  |   | REG. NO.   |  |   |  |  |         |
| 1. DECEASED NAME (TYPE OR PRINT)<br>Fanny J. Walsh  |  |  |  |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>April 27, 1983   |  |   | 2b. HOUR<br>9:35 A.M.  |  |         |
| 3. SEX<br>Female  |  | 4. RACE<br>White   |  | 5. DATE OF BIRTH<br>Jan. 22, 1912   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>71 YRS.   |   | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |         |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Kentucky   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |   |  |  |         |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Carriage Hill N.H. (Beth) |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Editor           |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>US Gov't.   |  |         |
| 13a. STATE<br>Md. 20816   |  |  | 13b. CITY<br>Montgomery  |   | 13c. CITY OR TOWN<br>Bethesda  |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>4 Ardmore Court 20816 |         |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Giddion W. Jasper   |  |  |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Lucy -- Coffee  |  |   |  |  |         |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----       |   | 17. INFORMANT ADDRESS Bethesda, Md.<br>Geoffrey E. Grant, 7510 New Market Dr.,   |  |   |  |  |         |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>1749 IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>METASTATIC BREAST CANCER</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>IMMED.<br>18 YRS. |  |  |  |   |  |  |   |  |  |         |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____   |  |  |  |   |  |  |   |  |  |         |
| 19a. DATE OF OPERATION  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                       |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |         |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)   |  |   |  |  |         |
| 21d. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |   |  |  |         |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>82</u> , to <u>4/27</u> , 19 <u>83</u> , that (I) (we) lost<br>saw the deceased alive on <u>4/26</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.   |  |  |  |   |  |  |   |  |  |         |
| 22b. SIGNATURE<br>Kevin G. Nealon, M.D.   |  |  |  |   | DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/27/83   |  |  |         |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>Kevin G. Nealon, M.D.  |  |  |  |   | 22e. ADDRESS<br>916 - 19th St. N.W. Wash., D.C. 20006  |  |   |  |  |         |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b. DATE<br>4/30/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>Gate of Heaven Cem.  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Silver Spring, Maryland                           |  |  |         |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br>Joseph Gawler's Sons, Inc.<br>5130 Wisc. Ave. N.W. Wash., D.C.  |  |  |  |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 2 1983  |  |   |  |  |         |
|   |  |  |  |   | 25b. REGISTRAR'S SIGNATURE<br>John J. Gawler   |  |   |  |  |         |

BP \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |  |  |  |  |                    |  |  |  |
|---|--|--|--|--|--|---|--|--|--|--|--|--------------------|--|--|--|
| 1- FOR STATE REGISTRAR  |  | 8 3 1 1 1 2 1  |  | REG. NO.   |  |   |  |  |  |  |  |                    |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  |  |  | 2a. DATE OF DEATH  |  | MONTH   |  | DAY  |  | YEAR   |  | 2b. HOUR           |  | A  |  |
| Mary M. Ward  |  |  |  | April 15, 1983   |  |   |  |  |  |  |  | 11:37 <sub>M</sub> |  |  |  |
| 3. SEX  |  | 4. RACE  |  | 5. DATE OF BIRTH   |  | 6. AGE (IN YEARS LAST BIRTHDAY)                                     |  | IF UNDER 1 YEAR  |  | IF UNDER 24 HRS.   |  |                    |  |  |  |
| Female  |  | Caucasian  |  | December 5, 1904   |  | 78 YRS.   |  | MONTHS   |  | DAYS   |  | HOURS              |  | MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)   |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH                                |  |  |  |  |  |                    |  |  |  |
| New York  |  | United States  |  |  |  | Montgomery County MD.   |  |  |  |  |  |                    |  |  |  |
| 10. CITY OR TOWN OF DEATH   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  | 12b. KIND OF BUSINESS OR INDUSTRY                                   |  |  |  |  |  |                    |  |  |  |
| Bethesda  |  | Fernwood House   |  | Housewife  |  | Own Home  |  |  |  |  |  |                    |  |  |  |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  | 13b. CITY OR TOWN  |  | 13c. INSIDE CITY LIMITS?   |  | 13d. STREET ADDRESS   |  | Zip Code: 14830  |  |  |  |                    |  |  |  |
| New York  |  | Steuben  |  | Corning  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 38 East Fifth Street   |  |  |  |                    |  |  |  |
| 14. FATHER'S NAME   |  | 15. MOTHER'S MAIDEN NAME   |  |  |  |   |  |  |  |  |  |                    |  |  |  |
| William Murray  |  | Katherine Maloney  |  |  |  |   |  |  |  |  |  |                    |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)   |  | 16b. SOCIAL SECURITY NO.   |  | 17. INFORMANT (Daughter)   |  | ADDRESS   |  |  |  |  |  |                    |  |  |  |
| No  |  | 097-38-3720  |  | Elizabeth W. Carter  |  | 5406 Huntington Parkway, Bethesda                                   |  |  |  |  |  |                    |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:   |  |  |  |  |  |   |  |  |  |  |  |                    |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
| 3352 IMMEDIATE CAUSE (a) Respiratory failure  |  |  |  |  |  |   |  |  |  |  |  |                    |  | Immediate                                    |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  |  |  |  |  |  |   |  |  |  |  |  |                    |  |  |  |
| (b) Anaphylactic shock  |  |  |  |  |  |   |  |  |  |  |  |                    |  |  |  |
| (c)   |  |  |  |  |  |   |  |  |  |  |  |                    |  |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:  |  |  |  |  |  |   |  |  |  |  |  |                    |  |  |  |
| 19a. DATE OF OPERATION  |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  | 20a. AUTOPSY?  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? |  |                    |  |  |  |
|   |  |  |  |  |  |   |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>            |  | YES <input type="checkbox"/> NO <input type="checkbox"/>       |  |                    |  |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  |  | 21b. TIME OF INJURY  |  |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) |  |  |  |                    |  |  |  |
|   |  |  |  | HOUR A.M. MONTH DAY YEAR   |  |   |  |  |  |  |  |                    |  |  |  |
| 21d. INJURY OCCURRED  |  |  |  | 21e. PLACE OF INJURY   |  |   |  | 21f. LOCATION  |  |  |  |                    |  |  |  |
| WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |  |  | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  |   |  | STREET CITY OR TOWN COUNTY STATE   |  |  |  |                    |  |  |  |
| 22a. I certify that (I) (the hospital) attended the deceased from 4/13/83, to 4/15/83, that (I) (we) lost saw the deceased alive on 4/13/83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death. |  |  |  | 4/13/83  |  |   |  | 4/15/83  |  |  |  |                    |  |  |  |
| 22b. SIGNATURE  |  |  |  | DEGREE   |  |   |  | 22c. DATE SIGNED   |  |  |  |                    |  |  |  |
| Horace W. Bernton   |  |  |  |  |  |   |  | 4/15/83  |  |  |  |                    |  |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)   |  |  |  | 22e. ADDRESS   |  |   |  |  |  |  |  |                    |  |  |  |
| Horace W. Bernton MD  |  |  |  | 4743 Bradley Blvd. Chevy Chase, MD   |  |   |  |  |  |  |  |                    |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)   |  |  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY                                  |  |  |  | 23d. LOCATION  |  |                    |  |  |  |
| Burial  |  |  |  | April 19, 1983   |  | St Mary Cemetery  |  |  |  | Corning, Steuben CO, N.Y.                                      |  |                    |  |  |  |
| 24. FUNERAL DIRECTOR  |  |  |  | 25a. BY REG.   |  |   |  | 25b. REGISTRAR'S SIGNATURE   |  |  |  |                    |  |  |  |
| Robert A. Pumphrey  |  |  |  | Homes, P.A., Bethesda, Maryland  |  |   |  | APR 21 1983  |  |  |  | John J. Smith      |  |  |  |



APR 21 1953



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copiers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |  |   |  |  |  |   |  | 8 3 1 1 1 2 2<br>REG. NO.   |  |
|--|--|--|--|---|--|--|--|---|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>Fern B. WATTS</b>   |  |  |  |   |  | 2a. DATE OF DEATH<br>MONTH <b>4</b> DAY <b>23</b> YEAR <b>83</b>                     |  | 2b. HOUR<br><b>6:35 PM</b>  |  |   |  |
| 3. SEX<br><b>Female</b>  |  | 4. RACE<br><b>White</b>  |  | 5. DATE OF BIRTH<br>MONTH <b>Feb.</b> DAY <b>23</b> YEAR <b>1893</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>90</b> YRS.                                    |  | IF UNDER 1 YEAR<br>MONTHS <b></b> DAYS <b></b>  |  | IF UNDER 24 HRS.<br>HOURS <b></b> MIN. <b></b>  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Kansas</b>   |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County, MD</b>                 |  |   |  |   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>4208 Heathfield Road</b> |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>own home</b>  |  |   |  |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)  |  |  |  |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |   |  |
| 13a. STATE<br><b>Maryland</b>  |  | 13b. COUNTY<br><b>Montgomery</b>   |  | 13c. CITY OR TOWN<br><b>Rockville</b>   |  | 13e. STREET ADDRESS<br><b>4208 Heathfield Road</b>                                   |  |   |  |   |  |
| 14. FATHER'S NAME<br>FIRST (Unknown) MIDDLE LAST <b>Guff</b>   |  |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST (Unknown) MIDDLE LAST <b>Rotroff</b>  |  |  |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <b>No</b>   |  |  |  | 16b. SOCIAL SECURITY NO.<br><b>511-20-7430</b>  |  | 17. INFORMANT<br><b>Margaret Jamitz - same as #13</b>                                |  |   |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4140</b> IMMEDIATE CAUSE (a) <b>Congestive heart failure</b>  |  |  |  |   |  |  |  |   |  | APPROXIMATE INTERVAL<br>BETWEEN ONSET AND DEATH<br><b>6 months.</b>   |  |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) <b>Atherosclerotic heart disease.</b>  |  |  |  |   |  |  |  |   |  | <b>5 years.</b>   |  |
| (c)  |  |  |  |   |  |  |  |   |  |   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):<br><b>Cardiac cachexia.</b>   |  |  |  |   |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION   |  |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |  | 20b. IF YES, WERE FINDINGS USED<br>IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>January</b> , 19 <b>83</b> , to <b>April</b> , 19 <b>83</b> , that (I) (we) lost<br>saw the deceased alive on <b>4/16/83</b> , and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death. |  |  |  |   |  |  |  |   |  |   |  |
| 22b. SIGNATURE<br><b>J. Maltz</b>  |  |  |  | DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  |  |  | 22c. DATE SIGNED<br><b>4/23/83.</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>JONATHAN MALTZ.</b>  |  |  |  | 22e. ADDRESS<br><b>1811 Prince Philip Drive, Olney, Md. 20832</b>   |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br><b>Burial</b>   |  |  |  | 23b. DATE<br><b>04-27-83</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Pine Lawn Mem. Park</b>                     |  | 23d. LOCATION<br>CITY OR TOWN <b>Amityville</b> COUNTY <b>Suffolk Co.</b> STATE <b>N.Y.</b> |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME <b>Hines/Rinaldi Funeral Home</b> ADDRESS <b>11800 New Hampshire Ave, Silver Spring, Md.</b>  |  |  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br><b>APR 26 1983</b>                                  |  | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Connel</b>   |  |   |  |





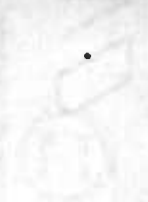
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   | 8 3 1 1 1 2 3<br>REG. NO.  |  |  |  |
|--|--|---|---|--|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br>Harry H. WEDELES   |  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 26, 1983  |  | 2b. HOUR<br>10:08pm  |  |
| 3. SEX<br>Male   | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 06, 1926   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>56 YRS.   |  | IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Austria   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Spring   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Holy Cross Hospital |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Technician   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>TV  |  |
| 13a. STATE<br>Maryland   | 13b. COUNTY<br>Montgomery  | 13c. CITY OR TOWN<br>Silver Spring  | 13d. INSIDE CITY LIMITS?<br><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | 13e. STREET ADDRESS<br>1006 Loxford Tce. 20901   |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Morris F. Wedeles  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Stella Weisz   |   |  |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>Yes  |  | 16b. SOCIAL SECURITY NO.<br>Korea 578-38-9280   |   | 17. INFORMANT<br>ADDRESS<br>Irving Miller; 204 Hannes St., SSpgM   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u><br>4100<br>DUE TO, OR AS A CONSEQUENCE OF<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |  |   |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a   |  |   |   |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED<br>(ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>3/31</u> , 19 <u>83</u> , to <u>4/26</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>4/22</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.         |  |   |   |  |  |  |  |
| 22b. SIGNATURE<br><u>Mark H. Elg</u>   |  | DEGREE  |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |  | 22c. DATE SIGNED<br>4/27/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARK H. ELG   |  | 22e. ADDRESS<br>MD 9801 Georgia Ave Silver Spring, Md   |   |  |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>Burial  |  | 23b. DATE<br>4-28-1983  |   | 23c. NAME OF CEMETERY OR CREMATORY<br>D.C. Lodge Cemetery  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Washington, D.C.   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Danzansky-Goldberg Chapels; 1170 Rockville Pike  |  |   |   | 25a. DATE REC'D. BY REGISTRAR<br>MAY 2 1983  |  |  |  |
|  |  |   |   | 25b. REGISTRAR'S SIGNATURE<br><u>John J. Conner</u>  |  |  |  |

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RECEIVED  
APRIL 25 1953  
MONTGOMERY  
TECHNICAL  
1006 LONDON TOL

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  | 8 3 1 1 1 2 4  |  |   |  |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR  |  |   |  | REG. NO.   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT) <b>Sylvia</b>  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR <b>4-5-83</b>   |  |   |  |
| 3. SEX <b>Female</b>  |  |   |  | 2b. HOUR <b>5:45</b> AM  |  |   |  |
| 4. RACE <b>white</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR <b>1-07-18</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.   |  | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NY</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH <b>Silver Spring</b>  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Holy Cross Hospital</b>   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>   |  |
| 13a. STATE <b>MARYLAND</b>  |  | 13b. COUNTY <b>MONTGOMERY</b>   |  | 13c. CITY OR TOWN <b>SILVER SPRING</b>   |  | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>BENNY GELLER</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>BECKIE GORDON</b>   |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>  |  | 16b. SOCIAL SECURITY NO. <b>577-05-6460</b>   |  |
| 17. INFORMANT <b>710 KERWIN ROAD</b>  |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Upper GI Bleeding</b> (10) <b>few days</b> (b) <b>Hepatic Metastases</b> (c) <b>Adenocarcinoma of Breast</b> <b>2 yrs 4 mo's</b> <b>10 yrs</b> |  | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>1749</b>             |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>Nov 11, 1980</b> to <b>4/5, 1983</b> that (I) (we) last saw the deceased alive on <b>4/4, 1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. |  | 22b. SIGNATURE <b>G. Lennard Gold, M.D.</b> DEGREE <b>M.D.</b>  |  | 22c. DATE SIGNED <b>4/5/83</b>   |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>G. LENNARD GOLD, M. D.</b>   |  | 22e. ADDRESS <b>8630 FENTON STREET SILVER SPRING, MARYLAND</b>  |  | 23a. BURIAL, CREMATION, REMOVAL <b>BURIAL</b>  |  | 23b. DATE <b>4/6/1983</b>   |  |
| 23c. NAME OF CEMETERY OR CREMATORY <b>JUDAEAN MEMORIAL GARDENS</b>  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>OLNEY, MONTGOMERY MARYLAND</b>   |  | 24. FUNERAL DIRECTOR OR STEIN HEBREW MEMORIAL FUNERAL HOME <b>232 CARROLL STREET, N. W., WASHINGTON, D. C.</b>   |  | 25. DATE REC'D. BY REGISTRAR <b>APR 8 1983</b>  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 4 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and a death certificate has been issued in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 1 2 5

REG. NO.

1- FOR  
STATE  
REGISTRAR

|  |  |  |   |   |  |  |                               |  |  |
|--|--|--|---|---|--|--|-------------------------------|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST Moe MIDDLE Weinstein LAST   |  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>4 6 '83                                  |   |  | 2b. HOUR<br>15 AM  |                               |  |  |
| 3. SEX<br>Male   |  | 4. RACE<br>Caucasian   |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>1 9 1900  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>83 YRS.   |                               | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Russia  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |                               |  |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Fernwood Nursing Home |   |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Owner (Ret.)     |                               | 12b. KIND OF BUSINESS OR INDUSTRY<br>Textile Bus.  |  |
| 13a. STATE<br>Maryland   |  |  |   |   | 13b. COUNTY<br>Montgomery  |  | 13c. CITY OR TOWN<br>Bethesda |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>UNKNOWN  |  |  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>UNKNOWN                                 |  |                               |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>NO   |  |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>-----<br>083-09-1115 |   | 17. INFORMANT<br>ADDRESS Maryland 20814<br>Mark Weinstein; 9522 Linden Avenue; Bethesda, |  |                               |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) Cardio-respiratory arrest<br>(c) Arteriosclerotic heart disease<br>DUE TO, OR AS A CONSEQUENCE OF<br>Generalized Arteriosclerosis<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>2 years<br>3 years |  |  |   |   |  |  |                               |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:6  |  |  |   |   |  |  |                               |  |  |
| 19a. DATE OF OPERATION   |  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                |   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |                               | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19                      |   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)       |                               |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)          |   |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                    |                               |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/6 19 81, to 4/6 19 83, that (I) (we) lost<br>saw the deceased alive on 2/26 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.  |  |  |   |   |  |  |                               |  |  |
| 22b. SIGNATURE<br>J. Blaine Fitzgerald M.D.<br>DEGREE<br>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>  |  |  |   |   |  | 22c. DATE SIGNED<br>4/6/83.  |                               |  |  |
| 23a. THIS PHYSICIAN'S NAME (TYPE OR PRINT)<br>J. Blaine Fitzgerald, M.D.   |  |  |   |   |  | 23b. ADDRESS<br>8218 Wisconsin Avenue; Bethesda, Maryland                            |                               |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>Burial  |  |  | 23b. DATE<br>4/7/83   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>New Montefiore Cemetery                            |  |                               | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Pinelawn; L.I.; New York   |  |
| 24. FUNERAL DIRECTOR<br>NAME DANZANSKY-GOLDBERG MEMORIAL CHAPELS<br>1170 Rockville Pike; Rockville, Maryland 20852   |  |  |   |   |  | 25. DATE REC'D. BY REGISTRAR<br>APR 11 1983 REGISTRAR'S SIGNATURE<br>John J. Connel  |                               |  |  |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 1 2 6

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |  |   |   |  |   |
|---|--|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>Jonathan Alan Weiser   |  |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>April 4, 1983  |  | 2b. HOUR<br>6:10 P <sub>M</sub>           |
| 3. SEX<br>Male  | 4. RACE<br>White   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>October 22, 1961  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br>21 YRS.                             | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN. |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Florida   | 7b. CITIZEN OF WHAT COUNTRY?<br>USA  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.          |   |
| 10. CITY OR TOWN OF DEATH<br>Bethesda   | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH<br>Clinical Center, Bethesda, Md. |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>student                     |  | 12b. KIND OF BUSINESS OR INDUSTRY         |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE<br>Florida | 13b. COUNTY<br>Plantation  | 13c. CITY OR TOWN<br>Plantation   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br>5620 S.W. 7th St 33317                          |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Irwin A. Weiser   |  |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Nancy J. Morrison                              |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>no  |  | 16b. SOCIAL SECURITY NO.<br>265-82-0243   |   | 17. INFORMANT<br>ADDRESS<br>Mrs. Nancy Weiser (mother) same as patient |   |

|   |  |  |
|---|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1991<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) Ewing's Sarcoma<br>(c) Thrombocytopenia |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Unknown<br>4 years<br>3 months |
|---|--|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no

|   |  |   |  |  |  |
|---|--|---|--|--|--|
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                                      |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)        |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                     |  |  |  |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>September 9</u> , 19 <u>78</u> , to <u>April 4</u> , 19 <u>83</u> , that <input checked="" type="checkbox"/> (we) lost <u>saw the deceased alive on April 4, 1983</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input checked="" type="checkbox"/> (not) view the body after death. |  |   |  |  |  |
| 22b. SIGNATURE<br><i>Marcia J. Browne MD</i>  |  | DEGREE<br>MD  |  | 22c. DATE SIGNED<br>4/4/83   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>MARCIA J. BROWNE MD.   |  | 22e. ADDRESS<br>National Institutes of Health<br>Clinical Center, Bethesda, Md. 20205 |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  | 23b. DATE<br>4-6-83  | 23c. NAME OF CEMETERY OR CREMATORY<br>Star of David Gardens                           |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>North Lauderdale, Fla                  |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Marshall's Funeral Home<br>4217 9th St NW: Washington, D.C.   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 11 1983  |  |  |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1 - FOR STATE REGISTRAR  |  | STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  | 8 3 1 1 1 2 7<br>REG. NO.   |   |
|--|--|---|--|---|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br><b>Anna Y. Wettengel</b>  |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>3 / 11 / 83</b>   |  | 7b. HOUR<br><b>10 P.M.</b>  |   |
| 3. SEX<br><b>Female</b>  | 4. RACE<br><b>White Caucasian</b>  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>8 / 8 / 05</b>   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>77</b> YRS.                                    | # UNDER 1 YEAR<br>MONTHS DAYS<br># UNDER 24 HRS<br>HOURS MIN.                               |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Maryland</b>   | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                        |   |   |
| 10. CITY OR TOWN OF DEATH<br><b>Bethesda</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Fernwood House Retirement &amp; N.C.</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Homemaker</b> | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>  |   |
| 13a. STATE<br><b>Md. 20814</b>   | 13b. COUNTY<br><b>Montgomery</b>   | 13c. CITY OR TOWN<br><b>Bethesda</b>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS<br><b>5015 Battery Lane 20814</b>                                       |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Robert Young</b>  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>Lucy Wade</b>   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>No</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>220-34-2946</b>  |  | 17. INFORMANT<br>ADDRESS<br><b>Dameron Md.<br/>Edmund Wettengel, Son, P.O. Box B Rt 235</b> |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY<br>IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b><br>4340<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last<br>(b) <b>Cerebral Atherosclerosis</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>5 minutes</b><br><b>Several years</b> |  |   |  |   |   |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)<br><b>Diabetes Mellitus Insulin dependent</b>  |  |   |  |   |   |
| 19a. DATE OF OPERATION<br><b>3/2/83</b>  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Anticipatory fracture</b>  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>        |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)              |   |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>February 19 56</b> to <b>11 March 19 83</b> , that (I) (we) lost<br>saw the deceased alive on <b>10 March 19 83</b> , and that in (my) opinion death occurred on the date and hour and from the causes stated<br>above. (If deceased did not view the body after death, so state.)   |  |   |  |   |   |
| 22b. SIGNATURE<br><b>Michael M. Healy MD</b>   |  | 22c. ADDRESS<br><b>5652 Shields Drive Bethesda MD 20817</b>   |  | 22d. DATE SIGNED<br><b>3/12/83</b>  |   |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>Burial</b>  |  | 23b. DATE<br><b>3/15/1983</b>   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Monocacy Cemetery</b>                       |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Beallsville, Maryland.</b> |
| 24. FUNERAL DIRECTOR<br><b>Joseph Gawler's Sons Inc.</b><br><b>5130 Wisc. Ave., N.W. Wash., D.C.</b>   |  |   | 25a. DATE REC'D. BY REGISTRAR<br><b>MAR 1 6 1983</b>                                 |   |   |
|  |  |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Gower</b>                                   |   |   |

BP



10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |  |  | 8 3 1 1 1 2 8<br>REG. NO. |  |
|--|--|---|--|--|---------------------------|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Nettie A Whipp  |  |   |  | 2a. DATE OF DEATH MONTH DAY YEAR<br>4 10 83  |                           |  |
| 3. SEX<br>FEMALE   |  | 4. RACE<br>White  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br>10 XXX 01   |                           | 2b. HOUR<br>2:15 A.M.  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>WASHINGTON, DC  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 6. AGE (IN YEARS (LAST BIRTHDAY))<br>81 YRS.   |                           | IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN.   |
| 10. CITY OR TOWN OF DEATH<br>WHEATON   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>BEL PRE. HEALTH CARE CENTER |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTG. MD.   |                           |  |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>CLERK   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>LIFE INSURANCE   |  |  |                           |  |
| 13a. STATE<br>MARYLAND   |  | 13b. COUNTY<br>MONTGOMERY   |  | 13c. CITY OR TOWN<br>WHEATON   |                           | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                            |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>ROBERT B. CAMPBELL  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>MARY J. SPEAKS  |  | 13e. STREET ADDRESS<br>2323 BLUERIDGE AVENUE 20902   |                           |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO.<br>577-40-5001   |  | 17. INFORMANT ADDRESS<br>DAUGHTER 1120 MIDVALE ROAD VIRGINIA R. FEARSON KENSINGTON, MD. 20895  |                           |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 4140 Congestive Heart Failure<br>DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Heart Disease<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>4 days |  |   |  |  |                           |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)  |  |   |  |  |                           |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |                           | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |                           |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)   |  | 21f. LOCATION CITY OR TOWN COUNTY STATE<br>STREET CITY OR TOWN COUNTY STATE  |                           |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/19 1980 to 4/10 1983 that (I) (we) last saw the deceased alive on 4/10 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.   |  |   |  |  |                           |  |
| 22b. SIGNATURE<br>K. J. Bernack  |  | DEGREE<br>M.D.  |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |                           | 22c. DATE SIGNED<br>4/19/83  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>K. J. Bernack   |  | 22e. ADDRESS<br>4115 Colie Drive, Wheaton   |  |  |                           |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>BURIAL  |  | 23b. DATE<br>4/13/83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>GATE OF HEAVEN   |                           | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>SILVER SPRING MONT MD.  |
| 24. FUNERAL DIRECTOR FRANCIS J. COLLINS<br>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901   |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 14 1983   |                           |  |
|  |  |   |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine   |                           |  |



20% COTTON

FILED IN



ACK

RECEIVED

1911



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

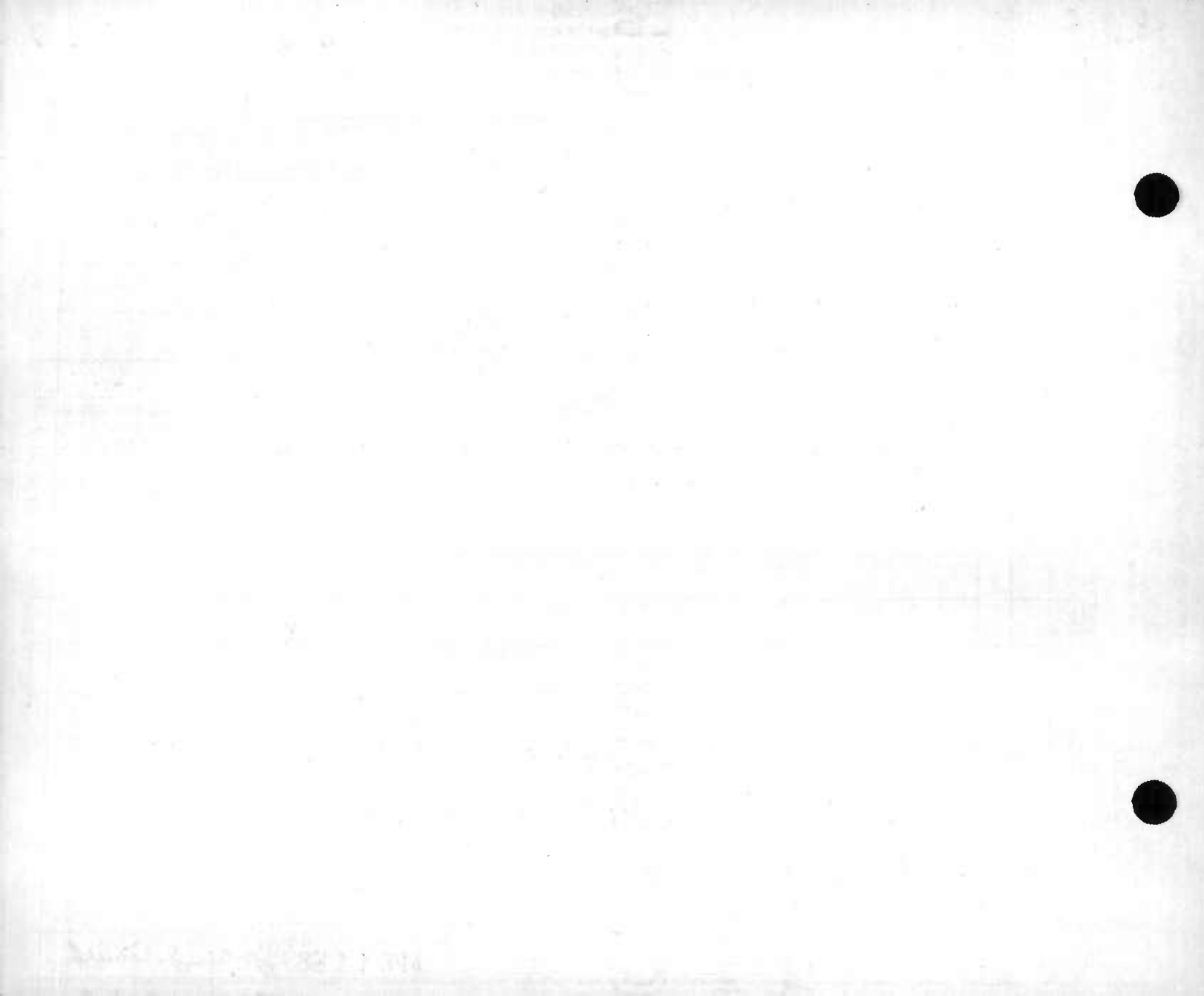
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, (pages 1 and 2) and file within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |  |   |  |  |   |  |   |  | 8 3 1 1 1 2 9 |
|--|--|--|---|--|--|---|--|---|--|---------------|
| 1. FOR<br>STATE<br>REGISTRAR   |  |  |   |  | REG. NO.   |   |  |   |  |               |
| 1 DECEASED NAME<br>(TYPE OR PRINT)<br>Leon Wynman Whitt  |  |  |   |  | 2a DATE OF DEATH<br>MONTH DAY YEAR<br>4 3 83                                   |   |  | 2b HOUR<br>925 P.M.   |  |               |
| 3 SEX<br>Male  |  | 4 RACE<br>Black  |   | 5 DATE OF BIRTH<br>MONTH DAY YEAR<br>Oct. 13, 1926   |  | 6 AGE (IN YEARS LAST BIRTHDAY)<br>56<br>YRS.  |  | 7 IF UNDER 1 YEAR<br>MONTHS DAYS<br>IF UNDER 24 HRS<br>HOURS MIN.   |  |               |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington, D.C.   |  | 7b CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |   | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9 BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery MD.                               |  |   |  |               |
| 10 CITY OR TOWN OF DEATH<br>Bethesda   |  | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>6807 Bradley Blvd. |   |  |  | 12a USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>Psychiatrist     |  | 12b KIND OF BUSINESS OR INDUSTRY<br>Medical   |  |               |
| 13a STATE<br>Maryland  |  |  | 13b COUNTY<br>Montgomery  |  | 13c CITY OR TOWN<br>Bethesda   |   | 13d INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |   | 13e STREET ADDRESS<br>6807 Bradley Blvd. 20817 |               |
| 14 FATHER'S NAME<br>FIRST MIDDLE LAST<br>Chauncey W. Whitt   |  |  |   |  | 15 MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Kathleen Roberts               |   |  |   |  |               |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>No  |  |  | 16b SOCIAL SECURITY NO.<br>578-34-4255                                |  | 17 INFORMANT ADDRESS<br>Md.<br>Constance W. Perry, 1808 Campbell Dr, Suitland, |   |  |   |  |               |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) 1539 HEPATIC FAILURE<br>DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC COLON CANCER<br>DUE TO, OR AS A CONSEQUENCE OF (c)<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>60 DAYS<br>2 YEARS |  |  |   |  |  |   |  |   |  |               |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |  |  |   |  |  |   |  |   |  |               |
| 19a DATE OF OPERATION  |  |  | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED                       |  |  | 20a AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |               |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |  | 21b TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |  | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)  |   |  |   |  |               |
| 21d INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |  | 21e PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |  | 21f LOCATION<br>STREET CITY OR TOWN COUNTY STATE                               |   |  |   |  |               |
| 22a I certify that (I) (this hospital) attended the deceased from 7/1/83, 19 83, to 4/3, 19 83, that (I) (we) lost saw the deceased alive on 4/1, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.              |  |  |   |  |  |   |  |   |  |               |
| 22b SIGNATURE<br>Victor M. Priego MD   |  |  |   |  | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c DATE SIGNED<br>April 4, 1983               |               |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT)<br>VICTOR M. PRIEGO MD  |  |  |   |  | 22e ADDRESS<br>3800 RESERVOIR RD NW WASHINGTON DC 20007                        |   |  |   |  |               |
| 23a BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |  | 23b DATE<br>7 April 1983  |  | 23c NAME OF CEMETERY OR CREMATORY<br>Lincoln Memorial                          |   | 23d LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Prince Georges, Md.   |   |  |               |
| 24 FUNERAL DIRECTOR<br>NAME<br>McGuire Funeral Service, Inc.   |  |  |   |  | ADDRESS<br>Wash, DC 7400 Georgia Ave NW  |   | 25a DATE REC'D. BY REGISTRAR<br>APR 11 1983  |   | 25b REGISTRAR'S SIGNATURE<br>John J. Connel    |               |

BP





Items #18a-22a Film G579 5/24/83 STATE OF MARYLAND  
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |  |                  |                 |   |  |  |  |   |                |   |  |   |  |  |               |   |  |  |  |
|---|--|------------------|-----------------|---|--|--|--|---|----------------|---|--|---|--|--|---------------|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT)   |  |                  | FIRST<br>ROSCOE |   |  | MIDDLE<br>CHESTER  |  |   | LAST<br>WILBON |   |  | 2a. DATE KNOWN OF DEATH<br>ESTIMATED <input checked="" type="checkbox"/> 4-9-83 19              |  |  | 2b. HOUR<br>M |   |  |  |  |
| 3. SEX<br>Male  |  | 4. RACE<br>Black |                 | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>7 24 46   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>36 YRS.                     |  | IF UNDER 1 YR.<br>MONTHS DAYS HOURS MIN   |                | 7c. DATE PRONOUNCED DEAD<br>4-10-83 19                      |  | 2d. HOUR<br>8:10A M   |  |  |               |   |  |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Wash. D.C.   |  |                  |                 | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |                |   |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County MD.                                   |  |  |               |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br>Silver Springs   |  |                  |                 | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Jessup Blair Park |  |  |  |   |                |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)                                   |  |  |               | 12b. KIND OF BUSINESS OR INDUSTRY               |  |  |  |
| 13a. STATE<br>Md.   |  |                  |                 | 13b. COUNTY<br>Montgomery   |  |  |  | 13c. CITY OR TOWN<br>Silver Spring  |                |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |               | 13e. STREET ADDRESS<br>1091 Ruatan Street 20903 |  |  |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Calvin Wilbon   |  |                  |                 |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Mary Anderson |  |   |                |   |  |   |  |  |               |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>Yes  |  |                  |                 | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>577-64-5452  |  |  |  | 17. INFORMANT<br>ADDRESS<br>Mary Wilbon Ruatan Street Silver Spring MD  |                |   |  |   |  |  |               |   |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):)<br>PART I DEATH WAS CAUSED BY:<br>3030 IMMEDIATE CAUSE (a) <u>Alcoholism</u><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |                  |                 |   |  |  |  |   |                |   |  |   |  |  |               |   |  |  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I 1a.  |  |                  |                 |   |  |  |  |   |                |   |  |   |  |  |               |   |  |  |  |
| 19a. DATE OF OPERATION  |  |                  |                 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?   |  |  |  |   |                |   |  | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |               |   |  |  |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |                 | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  |  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)   |                |   |  |   |  |  |               |   |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK   |  |                  |                 | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)   |  |  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |                |   |  |   |  |  |               |   |  |  |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> . |  |                  |                 |   |  |  |  |   |                |   |  |   |  |  |               |   |  |  |  |
| ACTUAL SIGNATURE<br><i>Margareta A. Korell</i>  |  |                  |                 | TITLE (SPECIFY)<br>Assistant  |  |  |  | MEDICAL EXAMINER  |                |   |  | DATE SIGNED<br>4-10-83  |  |  |               |   |  |  |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Margareta A. Korell, M.D.   |  |                  |                 | ADDRESS<br>111 Penn Street  |  |  |  |   |                |   |  |   |  |  |               |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  |                  |                 | 23b. DATE<br>4-16-83  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Lincoln Mem. Cemetery    |  |   |                | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Suitland, Md. |  |   |  |  |               |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>Johnson & Jenkins 716 Kennedy St. NW Wash DC  |  |                  |                 |   |  |  |  |   |                |   |  |   |  |  |               |   |  |  |  |
| 25a. DATE REC'D. BY REGISTRAR<br>APR 22 1983  |  |                  |                 |   |  |  |  |   |                |   |  |   |  |  |               |   |  |  |  |
| 25b. REGISTRAR'S SIGNATURE<br><i>John J. Canfield</i>   |  |                  |                 |   |  |  |  |   |                |   |  |   |  |  |               |   |  |  |  |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535



93B10010

ALL INFORMATION CONTAINED  
HEREIN IS UNCLASSIFIED  
DATE 10-10-2001 BY 60322  
UCBAW

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or translocation.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83

REG. NO.

1- FOR  
STATE  
REGISTRAR

|   |   |   |   |  |  |
|---|---|---|---|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <i>Beverly Jean Wilk Inson</i>  |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><i>4-25-83</i>                                    |  | 2b. HOUR<br><i>7 30 P.M.</i>   |
| 3. SEX<br><i>Female</i>   | 4. RACE<br><i>W</i>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><i>3 7 29</i>   |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><i>54</i> YRS.                                      |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><i>Ohio</i>  | 7b. CITIZEN OF WHAT COUNTRY?<br><i>Amer</i>   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><i>Montgomery</i> MD                           |  |
| 10. CITY OR TOWN OF DEATH<br><i>Montgomery</i>  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><i>Washington Adventist Hospital</i> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><i>HOME MAKER</i> |  | 12b. KIND OF BUSINESS OR INDUSTRY  |
| 13a. STATE<br><i>md</i>   |   | 13b. COUNTY<br><i>mont.</i>   | 13c. CITY OR TOWN<br><i>S.S.</i>  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> ? |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><i>Harold</i>   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><i>Florence Zeigler</i>  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) <i>No</i>         |  |
| 16b. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><i>Peterson L. Banker</i>  |   | ADDRESS<br><i>4909 N. Kinross Fresno Calif.</i>  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <i>inaction</i><br><i>1749</i><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:<br>(b) <i>metastatic breast cancer</i><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) |   |   |   |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a  |   |   |   |  |  |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><i>P.M. 19</i>   |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)         |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE                                      |  |
| 22a. I certify that (1) (this hospital) attended the deceased from <i>April 21, 1983</i> , to <i>April 25, 1983</i> , that (1) (we) lost saw the deceased alive on <i>April 21, 1983</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did not view the body after death.       |   |   |   |  |  |
| 22b. SIGNATURE<br><i>D.J. Naitak</i>  |   | DEGREE<br><i>MD</i>   |   | 22c. DATE SIGNED<br><i>4/24/83</i>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><i>D.J. NAITAK MD</i>  |   | 22e. ADDRESS<br><i>Hyattsville MD</i>   |   |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><i>Burial.</i>   |   | 23b. DATE<br><i>April 29-1983</i>   | 23c. NAME OF CEMETERY OR CREMATORY<br><i>George Washington Riggs Rd. Hyattsville,</i> |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><i>Pkes. Co. STATE</i>   |
| 24. FUNERAL DIRECTOR<br>NAME<br><i>R. J. Naitak</i>   |   | 24b. ADDRESS<br><i>254 Carroll St. N. W. Takoma Funeral Home, Inc.</i>  |   | 25a. DATE REC'D. BY REGISTRAR<br><i>APR 27 1983</i>                                    |  |
| 24c. REGISTRAR'S SIGNATURE  |   | 25b. REGISTRAR'S SIGNATURE<br><i>John J. Lamm</i>   |   |  |  |

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U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

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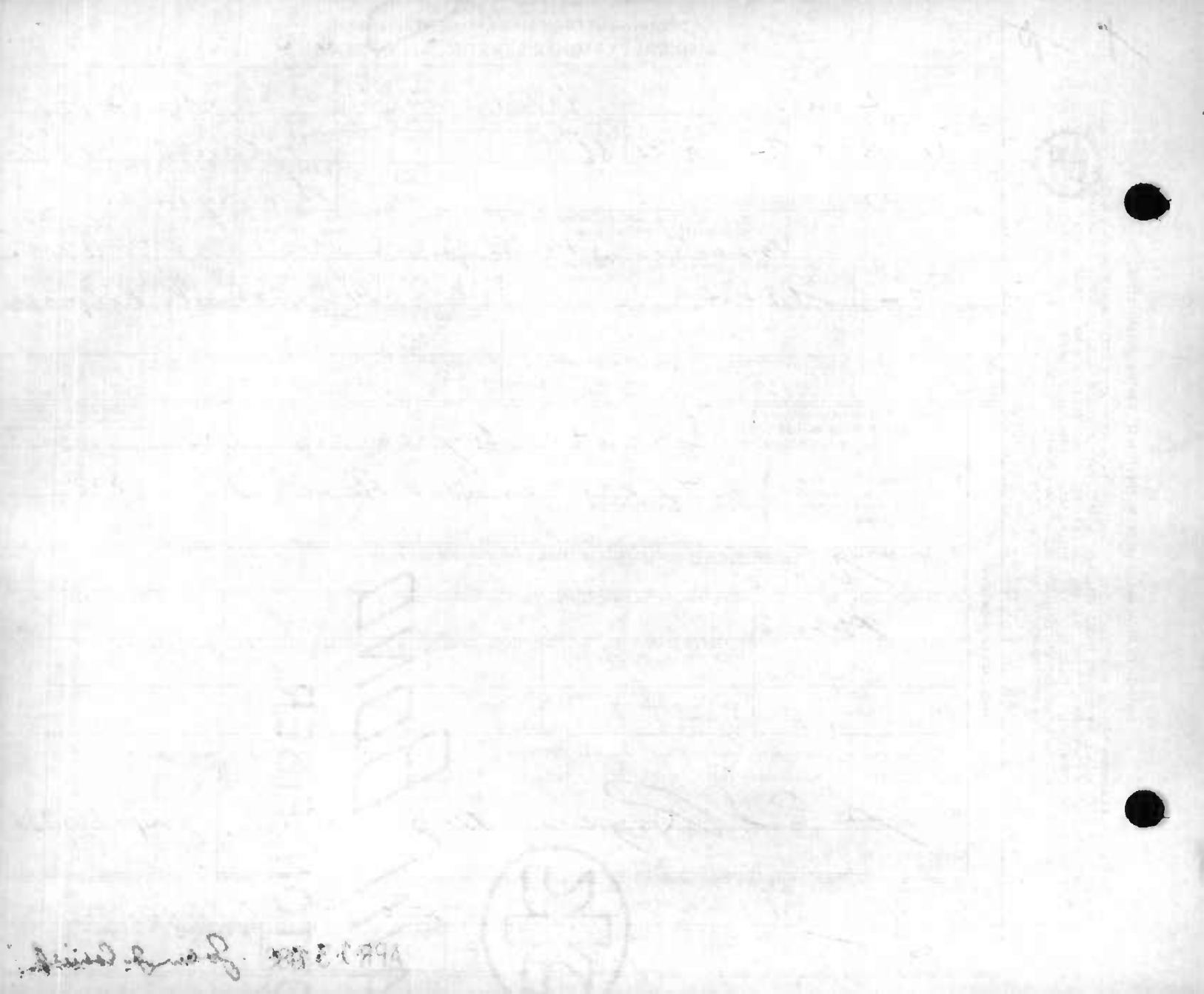
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF, MEDICAL EXAMINER, ALONG WITH FORM 10-1. RETAIN PAGE 5 TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

April 12, 1983 Creman's interred Washington National Cemetery  
Sui land, Maryland

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |   |  |  |  |  |  |  |  | REG. NO. 11133  |  |
|--|--|---|--|--|--|--|--|--|--|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>LOUIS WILLIAMS</b>  |  |   | 2a. DATE KNOWN OF DEATH ESTIMATED <b>March 29 83</b> |  |  | 2b. DATE KNOWN OF DEATH ESTIMATED <b>March 29 83</b>   |  |  | 2c. DATE KNOWN OF DEATH ESTIMATED <b>March 29 83</b> |   |  |
| 3. SEX <b>Male</b>   |  | 4. RACE <b>Black</b>  |  | 5. DATE OF BIRTH <b>Oct. 29, 1916</b>  |  | 6. AGE (IN YEARS) <b>66</b>  |  | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.   |  | 7b. HOUR <b>940</b>                                     |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Georgia</b>   |  | 7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH <b>Montgomery</b> MD.                                     |  |  |  |   |  |
| 10. CITY OR TOWN OF DEATH <b>Wheaton</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>14206 Grand Pk Rd Apt 3 D3</b> |  |  |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Retired/Post Office/Govt.</b> |  | 12b. KIND OF BUSINESS OR INDUSTRY <b>Ret.</b>                                    |  |   |  |
| 13a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Montgomery</b>  |  | 13b. CITY OR TOWN <b>Wheaton</b>  |  | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 13d. ADDRESS <b>14206 Grand Pk Rd Apt 3 D3</b>   |  |  |  |   |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas Williams</b>   |  |   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Janie Garner</b>   |  |  |  |  |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Army</b>   |  |   |  | 16b. SOCIAL SECURITY NO. <b>1943/1945</b>  |  | 17. INFORMANT <b>6506 Eastern Avenue, DC</b><br><b>Zella M. Pitts Williams (wife) Wash.</b>    |  |  |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br><b>4029</b> IMMEDIATE CAUSE (a) <b>Acute Myocardial Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.<br>(b) <b>Hypertensive Heart Dis.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>None</b>   |  |   |  |  |  |  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs</b> |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).<br><b>None</b>   |  |   |  |  |  |  |  |  |  |   |  |
| 19a. DATE OF OPERATION <b>None</b>   |  |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?  |  |  |  | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |  |   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)                  |  |  |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |  |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |  |  |   |  |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . |  |   |  |  |  |  |  |  |  |   |  |
| ACTUAL SIGNATURE <b>John S. Rogers</b>   |  |   |  | TITLE (SPECIFY) <b>M.D. Dep.</b>   |  |  |  | DATE SIGNED <b>April 6, 1983</b>   |  |   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>John S. Rogers</b>  |  |   |  | ADDRESS <b>1919 Seminary Road, Maryland</b>  |  |  |  |  |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Cremation</b>  |  | 23b. DATE <b>4/8/83</b>   |  | 23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>   |  |  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE <b>Suitland, P.G.Co. Maryland</b>        |  |   |  |
| 24. FUNERAL DIRECTOR NAME <b>LATNEY's</b>  |  |   |  | ADDRESS <b>3831 Ga. Ave. NW; Wash. DC</b>  |  |  |  | 25a. DATE REC'D. BY REGISTRAR <b>APR 13 1983</b>                                 |  | 25b. REGISTRAR'S SIGNATURE <b>John J. Canine</b>        |  |



1994-1995

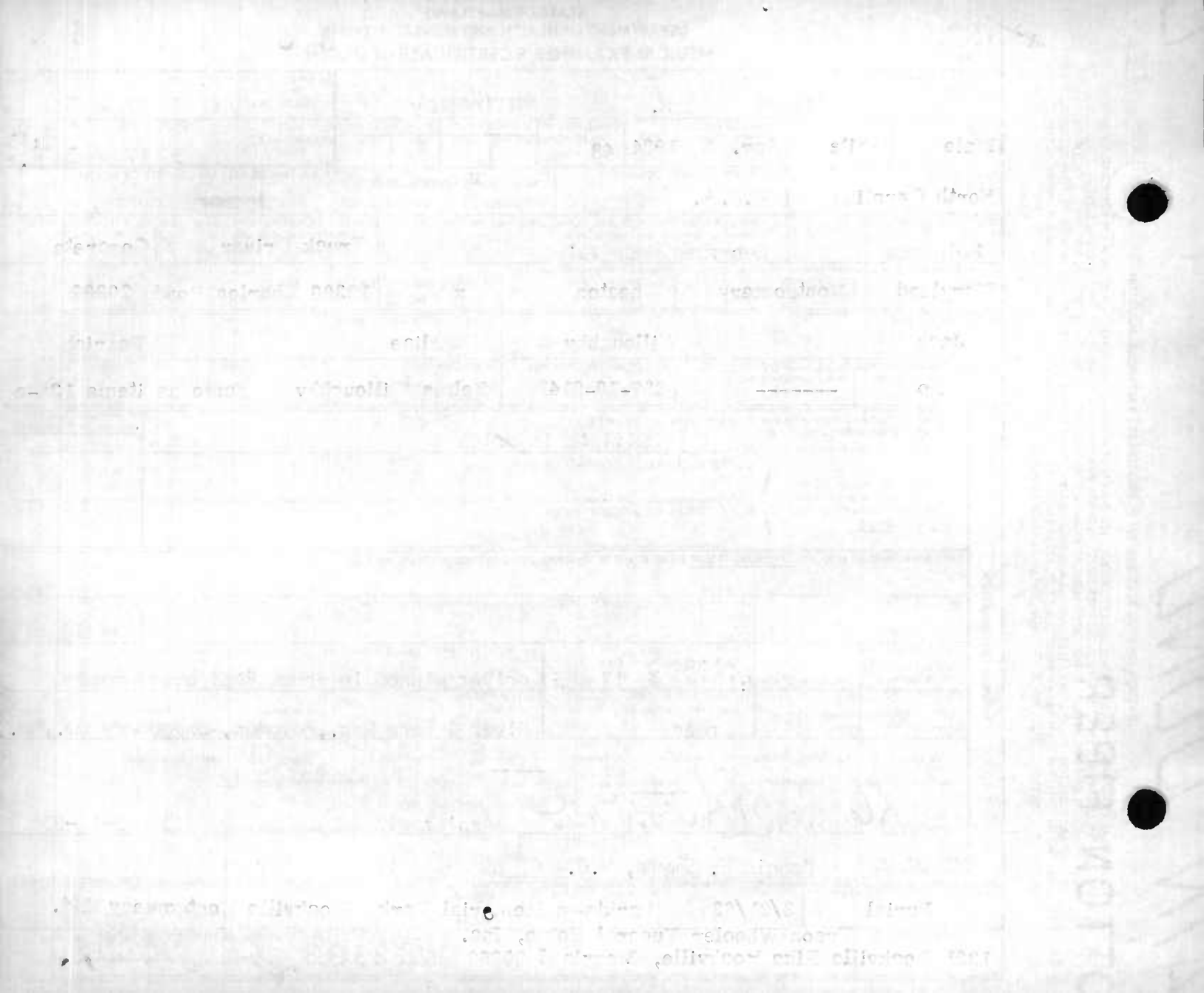


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17  
(VR A15 ME (5))  
20M 4/82

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>MEDICAL EXAMINER'S CERTIFICATE OF DEATH  |  |                  |   |  |  |   |  |   |   | REG. NO. 83 11134   |  |
|--|--|------------------|---|--|--|---|--|---|---|---|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) FIRST MIDDLE LAST<br>Wilbert H. Willoughby   |  |                  |   |  |  | 2a. DATE KNOWN OF DEATH<br>XX MONTH DAY YEAR<br>3 17 19 83  |  |   | 2b. HOUR<br>M<br>2:15 p.m.                                    |   |  |
| 3. SEX<br>Male   |  | 4. RACE<br>White |   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>Apr. 2 1934                      |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>48 YRS.  |  | 7. DATE PRONOUNCED DEAD<br>MONTH DAY YEAR<br>3 17 19 83 |   | 7b. HOUR<br>M<br>2:15 p.m.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>North Carolina  |  |                  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery County, MD |   |  |
| 10. CITY OR TOWN OF DEATH<br>Bethesda  |  |                  | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |  |  |   | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)<br>Truck Driver |   |   | 12b. KIND OF BUSINESS OR INDUSTRY<br>Concrete                                       |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>Jack Willoughby  |  |                  |   |  |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>Alice Parrish  |  |   |   |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN)<br>No  |  |                  |   | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>237-50-9141 |  | 17. INFORMANT<br>Zelma Willoughby   |  |   |   | ADDRESS<br>Same as items 13a-e  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) Multiple Injuries<br>8160<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____   |  |                  |   |  |  |   |  |   |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).  |  |                  |   |  |  |   |  |   |   |   |  |
| 19a. DATE OF OPERATION   |  |                  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?                      |  |   |  |   |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH   |  |                  |   | 21b. TIME OF INJURY<br>HOUR XX MONTH DAY YEAR<br>1:10 P.M. 3 17 1983   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br>driver pinned in truck that overturned                                     |  |   |   |   |  |
| 21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK <input checked="" type="checkbox"/> AT WORK   |  |                  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br>road    |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br>River & Tara Rds., Potomac, Montgomery Co., Md.  |  |   |   |   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |                  |   |  |  |   |  |   |   |   |  |
| ACTUAL SIGNATURE<br>Dennis F. Smyth M.D.   |  |                  |   | TITLE (SPECIFY)<br>M.D. Assistant                                      |  |   |  | MEDICAL EXAMINER<br>DATE SIGNED 3-18-83                 |   |   |  |
| EXAMINER'S NAME<br>(TYPE OR PRINT)<br>Dennis F. Smyth, M.D.  |  |                  |   | ADDRESS<br>111 Penn Street   |  |   |  |   |   |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial   |  |                  |   | 23b. DATE<br>3/21/83   |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Parklawn Memorial Park  |  |   |   | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Rockville Montgomery Md.              |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Tyson Wheeler Funeral Home, Inc.<br>1331 Rockville Pike Rockville, Maryland 20852  |  |                  |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br>MAR 23 1983  |  |   |   |   |  |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|---|--|
| 1. FOR<br>STATE<br>REGISTRAR  |  | 8 3 1 1 1 3 5   |  | REG. NO.  |  |   |  |   |  |
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>DAVID GLENN WILSON   |  |   |  | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br>APRIL 3 1983   |  | 2b. HOUR<br>3:35 <sup>a</sup> M   |  |   |  |
| 3. SEX<br>MALE  |  | 4. RACE<br>CAUCASIAN  |  | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br>NOVEMBER 4 1930   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>52 YRS   |  | 7. IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>MISSISSIPPI  |  | 7b. CITIZEN OF WHAT COUNTRY?<br>UNITED STATES   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>MONTGOMERY MD.  |  |   |  |
| 10. CITY OR TOWN OF DEATH<br>BETHESDA   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>NAVAL HOSPITAL |  |   |  | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br>RETIRED                     |  | 12b. KIND OF BUSINESS OR INDUSTRY<br>U.S. NAVY  |  |
| 13a. STATE<br>VIRGINIA  |  | 13b. COUNTY<br>FAIRFAX  |  | 13c. CITY OR TOWN<br>VIENNA   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>505 WOODLAND COURT 99999   |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br>ALBERT PEARSON WILSON   |  |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br>BLANCHE CANNON   |  |   |  |   |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br>YES   |  |   |  | 16b. SOCIAL SECURITY NO.<br>(IF YES, GIVE WAR OR DATES)<br>1950-1982  |  | 17. INFORMANT<br>ADDRESS<br>EUGENE C. WILSON, 14830 LAQUINTA, HOUSTON, TX 77079                 |  |   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br>5715 IMMEDIATE CAUSE (a) CIRRHOSIS<br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.<br>(b) DUE TO, OR AS A CONSEQUENCE OF<br>(c) |  |   |  |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16  |  |   |  |   |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>            |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |   |  |   |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from MARCH 21 19 83, to APRIL 3 19 83, that (I) (we) lost saw the deceased alive on APRIL 3 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.       |  |   |  |   |  |   |  |   |  |
| 22b. SIGNATURE<br>M. S. Miller  |  |   |  | DEGREE<br>M.D.  |  |   |  | 22c. DATE SIGNED<br>4/4/83  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>M. S. MILLER, LT, MC, USNR   |  |   |  | 22e. ADDRESS<br>NAVAL HOSPITAL, NAVAL MEDICAL COMMAND, NATIONAL CAPITAL REGION, BETHESDA, MD 20814  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br>Burial  |  | 23b. DATE<br>April 6, 1983  |  | 23c. NAME OF CEMETERY OR CREMATORY<br>Arlington National  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br>Arlington, Virginia                               |  |   |  |
| 24. FUNERAL DIRECTOR<br>NAME<br>Money & King<br>171 W. Maple Ave., Vienna, Va. 22180  |  |   |  | 25a. DATE REC'D. BY REGISTRAR<br>APR 11 1983  |  | 25b. REGISTRAR'S SIGNATURE<br>John J. Canine  |  |   |  |



IV

CHIL-100

APR 11 1954

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |   |                             |   |   |  |  |  |   | 8 3 1 1 1 3 6<br>REG. NO.  |  |  |
|---|--|---|-----------------------------|---|---|--|--|--|---|--|--|--|
| 1. DECEASED NAME<br>(TYPE OR PRINT) <b>HARRY O'NEAL WILSON, Jr.</b>   |  |   |                             |   | 2a. DATE OF DEATH MONTH DAY YEAR<br><b>4-27-83</b>                  |  |  | 2b. HOUR<br><b>10<sup>07</sup> A.M.</b>  |   |  |  |  |
| 3. SEX<br><b>MALE</b>   |  | 4. RACE<br><b>CAUCASIAN</b>   |                             | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>JULY 31, 1912</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b> YRS.  |  | IF UNDER 1 YEAR<br>MONTHS DAYS HOURS MIN.  |   | IF UNDER 24 HRS.<br>HOURS MIN.   |  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>MARYLAND</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                             | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.                                  |  |  |   |  |  |  |
| 10. CITY OR TOWN OF DEATH<br><b>TAKOMA PARK</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>WASHINGTON ADVENTIST HOSPITAL</b> |                             |   |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>INSURANCE EXECUTIVE</b> |  |  | 12b. KIND OF BUSINESS OR INDUSTRY   |  |  |  |
| 13a. STATE<br><b>MARYLAND</b>   |  |   |                             |   | 13b. COUNTY<br><b>MONTGOMERY</b>                                    |  | 13c. CITY OR TOWN<br><b>KENSINGTON</b> |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>10030 KENSINGTON PARKWAY</b> 20795 |  |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>HARRY O. WILSON</b>  |  |   |                             |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE LAST<br><b>MARY WALLER</b> |  |  |  |   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)<br><b>NO</b>   |  |   |                             |   | 16b. SOCIAL SECURITY NO.<br><b>212-01-2114</b>                      |  | 17. INFORMANT<br><b>SON</b>            |  | ADDRESS<br><b>439 CUDORA STREET DENVER, COLO 80220</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART I. DEATH WAS CAUSED BY:<br><b>4149</b> IMMEDIATE CAUSE (a) <b>Anoxic Brain Damage</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>(b) <b>Ventricular arrhythmia.</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) <b>Coronary artery disease.</b> |  |   |                             |   |   |  |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 days.</b><br><b>10 yr.</b><br><b>20 yr.</b>                           |  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)<br><b>Subdural hematoma.</b>   |  |   |                             |   |   |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  |   |                             | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   |  |  | 20a. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER, NOTIFY MEDICAL EXAMINER)  |  |   |                             | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br>P.M. 19  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b. PART 1 OR PART 2)                 |  |  |   |  |  |  |
| 21d. INJURY OCCURRED<br>WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/><br>AT WORK AT WORK  |  |   |                             | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE  |  |  |   |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/22</b> , 19 <b>83</b> , to <b>4/27</b> , 19 <b>83</b> , that (I) (we) last saw the deceased alive on <b>4/27</b> , 19 <b>83</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.  |  |   |                             |   |   |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Keith M. Lindgren MD</b>   |  |   |                             |   |   |  |  | DEGREE<br><b>MD</b>  |   | 22c. DATE SIGNED<br><b>4/27/83</b>   |  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Keith M. Lindgren MD</b>  |  |   |                             |   |   |  |  | 22e. ADDRESS   |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL<br>(SPECIFY)<br><b>BURIAL</b>   |  |   | 23b. DATE<br><b>4/29/83</b> |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>PARKLAWN CEMETERY</b>      |  |  | 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>ROCKVILLE MONT MD.</b>              |   |  |  |  |
| 24. FUNERAL DIRECTOR<br>NAME ADDRESS<br><b>FRANCIS J. COLLINS</b><br><b>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</b>   |  |   |                             |   |   |  |  | 25a. DATE REC'D. BY REGISTRAR<br><b>MAY 2 1983</b>                                   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Conner</b>  |  |  |

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Handwritten text on lined paper, mostly illegible due to fading. Some visible words include "The", "of", "and", "in", "on", "at", "from", "to", "by", "with", "without", "under", "above", "below", "between", "among", "against", "towards", "from", "to", "by", "with", "without", "under", "above", "below", "between", "among", "against", "towards".



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DOOR COLL

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  |  |  |   |  |   |  |
|---|--|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR  |  | 8 3 1 1 1 3 7  |  | REG. NO.   |  |   |  |   |  |
| 1. DECEASED NAME (TYPE OR PRINT)  |  | FIRST MABEL MIDDLE E LAST WINSLOW  |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR  |  |   |  |
| 3. SEX Female   |  | 4. RACE White  |  | 5. DATE OF BIRTH MONTH DAY YEAR 12 3 1891  |  | 6. AGE (IN YEARS LAST BIRTHDAY) 91 YRS.   |  | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.                    |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York  |  | 7b. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.   |  |   |  |
| 10. CITY OR TOWN OF DEATH Silver Spring   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Chevy Chase Ret. N.C. |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker  |  | 12b. KIND OF BUSINESS OR INDUSTRY Home  |  |   |  |
| 13a. STATE Md. 20816  |  | 13b. COUNTY Montgomery   |  | 13c. CITY OR TOWN Bethesda   |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>                                       |  | 13e. STREET ADDRESS 5603 Harwick Road 20816                                   |  |
| 14. FATHER'S NAME FIRST Charles MIDDLE H. LAST Winslow  |  | 15. MOTHER'S MAIDEN NAME FIRST Hannah MIDDLE Edgar LAST  |  | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No   |  | 16b. SOCIAL SECURITY NO. 579-60-3996  |  | 17. INFORMANT ADDRESS Maryland. Harold B. Master. 5603 Harwick Road, Bethesda |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART 1. DEATH WAS CAUSED BY:<br>4409 IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u><br>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized arteriosclerosis</u><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) _____ |  |  |  |  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                  |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____  |  |  |  |  |  |   |  |   |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |   |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |   |  |   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |   |  |   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 8 December, 19 55, to 21 April, 19 83, that (I) (we) lost above, (I) (we) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |   |  |
| 22b. SIGNATURE Alfred Baer  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>               |  | 22c. DATE SIGNED 21 April 83  |  |   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) ALFRED BAER, M.D.   |  | 22e. ADDRESS 730 24th Street, NW Washington, D.C. 20037  |  |  |  |   |  |   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation   |  | 23b. DATE 4/22/1983  |  | 23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Crematory  |  | 23d. LOCATION CITY OR TOWN COUNTY STATE Suitland Maryland.  |  |   |  |
| 24. FUNERAL DIRECTOR Joseph Gawler's Sons Inc. 5130 Wisc. Ave., N.W. Wash., D.C.  |  |  |  | 25a. DATE REC'D. BY REGISTRAR APR 25 1983  |  | 25b. REGISTRAR'S SIGNATURE John J. Connel   |  |   |  |

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U.S. DEPARTMENT OF THE ARMY  
OFFICE OF THE ADJUTANT GENERAL  
WASHINGTON, D.C.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 8311138  |  |  |  |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR  |  |  |  | 2a. DATE OF DEATH MONTH DAY YEAR  |  |  |  |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br><b>Violet ELIZABETH Wood</b>  |  |  |  | 2b. HOUR<br><b>April 11, 1983 11:00 PM</b>  |  |  |  |
| 3. SEX<br><b>FEMALE</b>   |  | 4. RACE<br><b>WHITE</b>  |  | 5. DATE OF BIRTH MONTH DAY YEAR<br><b>March 11, 1913</b>  |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>70</b>   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Missouri</b>  |  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery</b> MD.  |  |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>H. Wife</b>   |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>Home</b>   |  |
| 13a. STATE<br><b>Md. 20906</b>  |  | 13b. COUNTY<br><b>Mont.</b>  |  | 13c. CITY OR TOWN<br><b>Silver Spring</b>   |  | 13d. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                            |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br><b>John - Gray</b>   |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br><b>Chauncie - Attebury</b>   |  | 16. STREET ADDRESS<br><b>14602 Deerhurst Terr. 2906</b>   |  |  |  |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br><b>no</b>  |  | 16b. SOCIAL SECURITY NO.<br><b>184-07-1872</b>   |  | 17. INFORMANT ADDRESS<br><b>Louvan E. Wood Same as #13</b>  |  |  |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>Chronic CA - motor Fatigue</b><br><b>1830</b><br>DUE TO, OR AS A CONSEQUENCE OF<br>Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last.<br>(b) _____<br>DUE TO, OR AS A CONSEQUENCE OF<br>(c) _____ |  |  |  |   |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)  |  |  |  |   |  |  |  |
| 19a. DATE OF OPERATION  |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)  |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br><b>P.M. 19</b>   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)  |  |  |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>  |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE  |  |  |  |
| 22a. I certify that (I) (this hospital) attended the deceased from <b>4/11/1983</b> to <b>4/11/1983</b> , that (I) (we) last saw the deceased alive on <b>4/11/1983</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 22b. SIGNATURE<br><b>Allan Cohan</b>  |  | DEGREE   |  | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>                  |  | 22c. DATE SIGNED<br><b>4/12/83</b>   |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Allan Cohan, M.D.</b>   |  | 22e. ADDRESS<br><b>Silver Spring, Md.</b>  |  |   |  |  |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>BURIAL</b>  |  | 23b. DATE<br><b>APR. 14, 1983</b>  |  | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Christ Church Cem.</b>   |  | 23d. LOCATION CITY OR TOWN COUNTY STATE<br><b>Chaptico St. Marys Md.</b>   |  |
| 24. FUNERAL DIRECTOR (NAME)<br><b>FRANCIS H. BARBER LAYTONSVILLE, MD. 20879</b>   |  |  |  | 25. REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE<br><b>APR 18 1983 [Signature]</b>  |  |  |  |

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

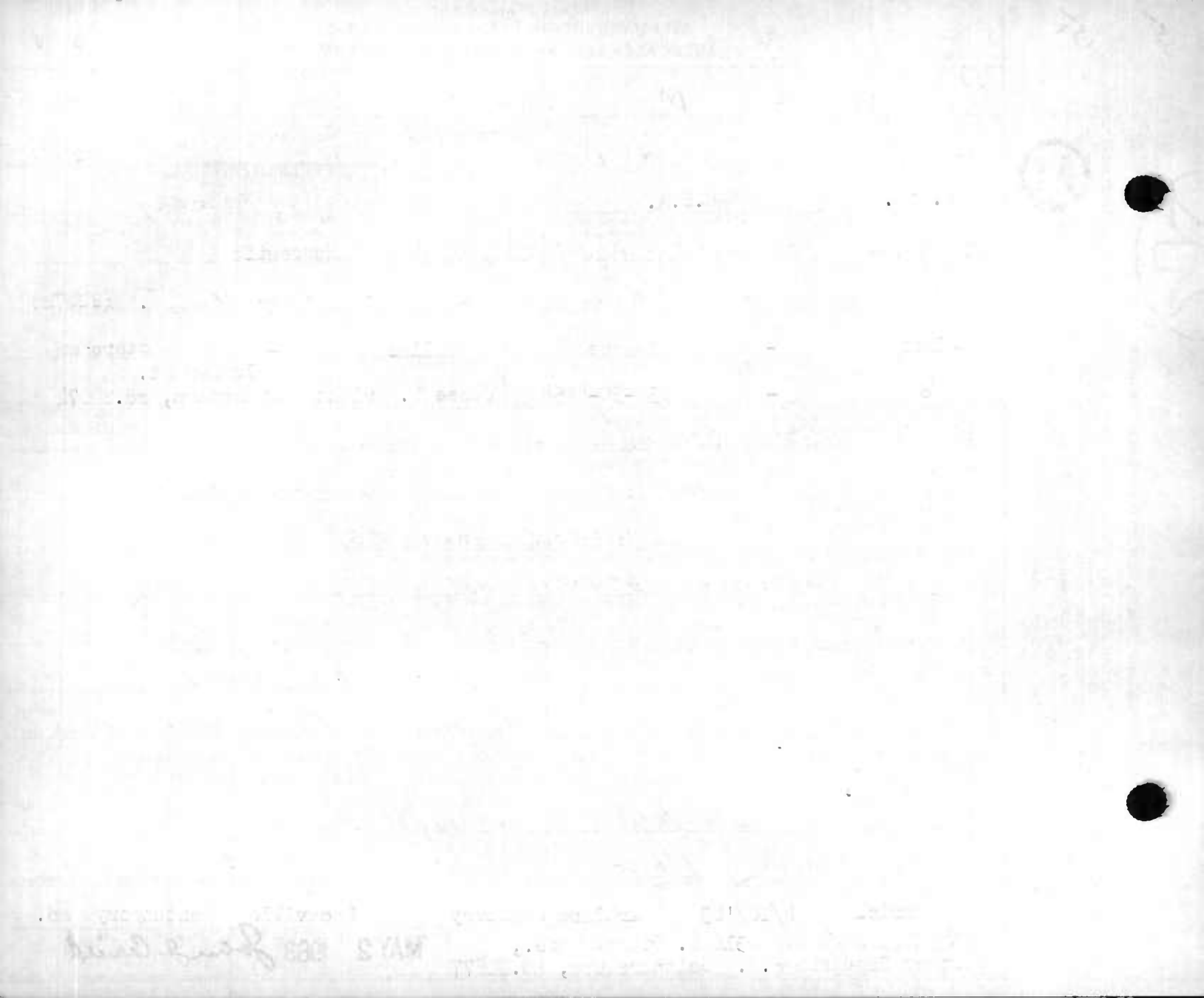
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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

|   |                        |   |  |   |  |  |   |   |   |                                   |                   |   |  |                   |  |
|---|------------------------|---|--|---|--|--|---|---|---|-----------------------------------|-------------------|---|--|-------------------|--|
| 1. FOR STATE REGISTRAR  |                        | 2. DECEASED NAME<br>(TYPE OR PRINT) <b>Phyllis M. Wright</b>  |  |   |  |  |   |   |   |                                   |                   | 2a. DATE KNOWN OF DEATH<br>MONTH <input checked="" type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> 4 25 1983 |  | 2b. HOUR<br>11 5A |  |
| 3. SEX<br><b>F</b>  | 4. RACE<br><b>CAUC</b> | 5. DATE OF BIRTH<br>MONTH <b>5</b> DAY <b>20</b> YEAR <b>34</b>   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>48</b> YRS.   |  | 7. IF UNDER 1 YR.<br>MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>   | 8. IF UNDER 24 HRS.<br>HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> |   | 2c. DATE PRONOUNCED DEAD<br>MONTH <b>4</b> DAY <b>25</b> YEAR <b>1983</b> |                                   | 2d. HOUR<br>11 5A |   |  |                   |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>W. Va.</b>  |                        | 7b. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |   |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>MONTGOMERY</b> MD.   |   |                                   |                   |   |  |                   |  |
| 10. CITY OR TOWN OF DEATH<br><b>Rockville</b>   |                        | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Shady Grove Adventist Hospital</b> |  |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Housewife</b>  |   |   |   | 12b. KIND OF BUSINESS OR INDUSTRY |                   |   |  |                   |  |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE <b>MD</b> 13b. COUNTY <b>MONTGOMERY</b> 13c. CITY OR TOWN <b>GERMANTOWN</b>  |                        |   |  | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br><b>6 Plummer Ct. (20871)</b>  |   |   |   |                                   |                   |   |  |                   |  |
| 14. FATHER'S NAME<br>FIRST <b>Delmar</b> MIDDLE <b>-</b> LAST <b>Simmons</b>  |                        |   |  | 15. MOTHER'S MAIDEN NAME<br>FIRST <b>Pauline</b> MIDDLE <b>-</b> LAST <b>Starcher</b>           |  |  |   | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO, OR UNKNOWN) <b>No</b>                                     |   |                                   |                   |   |  |                   |  |
| 16b. SOCIAL SECURITY NO.<br><b>234-50-8954</b>  |                        |   |  | 17. INFORMANT<br><b>Jesse S. Wright</b>   |  |  |   | 17. ADDRESS<br><b>6 Plummer Ct. Germantown, Md. 20871</b>   |   |                                   |                   |   |  |                   |  |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) <b>CARDIO RESPIRATORY ARREST</b><br>4560<br>Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:<br>(b) <b>MASSIVE GASTROINTESTINAL HEMORRHAGE</b><br>(c) <b>ESOPHAGEAL VARICES</b><br>ACUTE<br>YVS  |                        |   |  |   |  |  |   |   |   |                                   |                   |   |  |                   |  |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).<br><b>CIRRHOSIS - ETHANOLISM</b>  |                        |   |  |   |  |  |   |   |   |                                   |                   |   |  |                   |  |
| 19a. DATE OF OPERATION<br><b>-</b>  |                        |   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?<br><b>-</b>                                   |  |  |   | 20. AUTOPSY?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |   |                                   |                   |   |  |                   |  |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH  |                        |   |  | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>P.M. - 19</b>                             |  |  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)<br><b>COLLAPSED AT HOME</b>           |   |                                   |                   |   |  |                   |  |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK  |                        |   |  | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)<br><b>HOME</b>                      |  |  |   | 21f. LOCATION<br>STREET <b>6 Plummer Ct</b> CITY OR TOWN <b>GERMANTOWN</b> COUNTY <b>MONTGOMERY</b> STATE <b>MD</b> |   |                                   |                   |   |  |                   |  |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                        |   |  |   |  |  |   |   |   |                                   |                   |   |  |                   |  |
| ACTUAL SIGNATURE <b>Francis C Mayle</b>   |                        |   |  | TITLE (SPECIFY)<br><b>Dept</b>  |  |  |   | DATE SIGNED<br><b>4/26/83</b>   |   |                                   |                   |   |  |                   |  |
| EXAMINER'S NAME (TYPE OR PRINT) <b>FRANCIS C MAYLE</b>  |                        |   |  | ADDRESS<br><b>800 Wisconsin Ave Bethesda MD</b>   |  |  |   |   |   |                                   |                   |   |  |                   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |                        |   |  | 23b. DATE<br><b>4/28/83</b>   |  |  |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Parklawn Cemetery</b>  |   |                                   |                   | 23d. LOCATION<br>CITY OR TOWN <b>Rockville</b> COUNTY <b>Montgomery</b> STATE <b>Md.</b>  |  |                   |  |
| 24. FUNERAL DIRECTOR<br><b>Francis H. Sandison</b>  |                        |   |  | ADDRESS<br><b>316 E. Diamond Ave., Gaithersburg, Md. 20877</b>                                  |  |  |   | 25a. DATE REC'D BY REGISTRAR<br><b>MAY 2 1983</b>   |   |                                   |                   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Carver</b>   |  |                   |  |





STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

83 11140  
REG. NO.

FOR  
1- STATE REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST **GLADYS F. YOUNG**

2a. DATE OF DEATH MONTH DAY YEAR **4 7 83** 2b. HOUR **8:14 AM**

3. SEX **Female** 4. RACE **White** 5. DATE OF BIRTH MONTH DAY YEAR **7 14 1906** 6. AGE (IN YEARS LAST BIRTHDAY) **76** YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **Maryland** 7b. CITIZEN OF WHAT COUNTRY? **U.S.A.** 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH **Montgomery County** MD.

10. CITY OR TOWN OF DEATH **Silver Spring** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **Holy Cross Hospital** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **Practical Nurse** 12b. KIND OF BUSINESS OR INDUSTRY

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE **Maryland** 13c. COUNTY **Howard** 13d. CITY OR TOWN **Mt. Airy** 13e. INSIDE CITY LIMITS? YES ☐ NO ☒ 13f. STREET ADDRESS **16624 Frederick Rd. 21771**

14. FATHER'S NAME FIRST MIDDLE LAST **John Franklin Young** 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST **Mary G. Warfield**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) **No** 16b. SOCIAL SECURITY NO. **216-07-3257** 17. INFORMANT ADDRESS **Rose Warfield, 110 S. Washington St. Rockville, Md.**

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) **Cardiomyopathy arrest** APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH **2-3 m.h.**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Systolic** 1 WK.

(c) **Diabetes mellitus + soft tissue infection** 1 WK.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) **Diabetes mellitus, chronic renal failure**

19a. DATE OF OPERATION **3/30/83** 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED **Perforated ulcer + jaundice @ hyp** 20a. AUTOPSY? YES ☐ NO ☒ 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR **19** 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE ☐ NOT WHILE ☐ AT WORK AT WORK 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) **19** 21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **3/30/83**, 19 **83**, to **4 17**, 19 **83**, that (I) (we) last saw the deceased alive on **4/5**, 19 **83**, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE **John E. Allen** DEGREE **4/7/83** 22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **A. E. ALLEN** 22e. ADDRESS **3915 Ferrara Dr. WILKINSON**

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) **Burial** 23b. DATE **Apr. 9, 1983** 23c. NAME OF CEMETERY OR CREMATORY **Damascus Meth.** 23d. LOCATION CITY OR TOWN COUNTY STATE **Damascus, Montg., Md.**

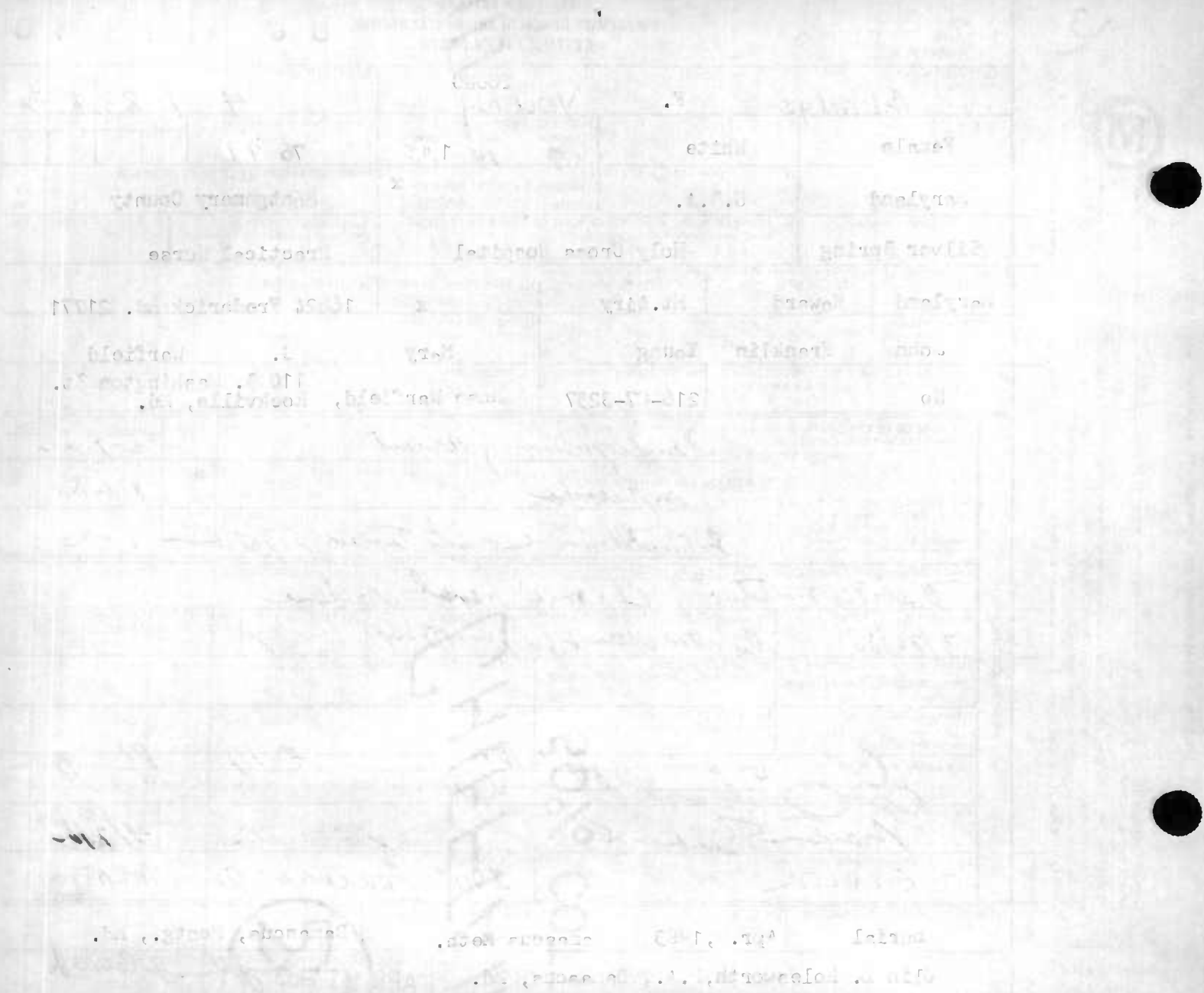
24. FUNERAL DIRECTOR NAME **Olin L. Molesworth, P.A.** ADDRESS **Damascus, Md.** 25a. DATE REC'D. BY REGISTRAR **APR 11 1983** 25b. REGISTRAR'S SIGNATURE **John J. Smith**

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 1 4 1

REG. NO.

FOR  
1. STATE  
REGISTRAR

|   |   |   |   |  |   |
|---|---|---|---|--|---|
| 1. DECEASED NAME<br>(TYPE OR PRINT)<br>FIRST MIDDLE LAST<br><b>Russel G. Young</b>  |   |   | 2a. DATE OF DEATH<br>MONTH DAY YEAR<br><b>April 25, 1983</b>                                    |  | 2b. HOUR<br><b>7:45a</b>                                    |
| 3. SEX<br><b>Male</b>   | 4. RACE<br><b>White</b>   | 5. DATE OF BIRTH<br>MONTH DAY YEAR<br><b>May 17 1896</b>  |   | 6. AGE (IN YEARS LAST BIRTHDAY)<br><b>86</b>   | 7. IF UNDER 1 YEAR<br>MONTHS DAYS<br><b>YRS.</b>            |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br><b>Pennsylvania</b>  | 7b. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 9. BALTIMORE CITY OR COUNTY OF DEATH<br><b>Montgomery County</b> MD                                    |   |
| 10. CITY OR TOWN OF DEATH<br><b>Olney</b>   | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION<br>(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br><b>Montgomery General Hospital</b> |   | 12a. USUAL OCCUPATION<br>(TYPE OF WORK FOR MOST OF WORKING LIFE)<br><b>Attorney</b>             |  | 12b. KIND OF BUSINESS OR INDUSTRY<br><b>US Govt.</b>        |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)<br>13a. STATE 13b. COUNTY 13c. CITY OR TOWN<br><b>Maryland Montgomery Silver Spring</b>  |   |   | 13d. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |   |
| 14. FATHER'S NAME<br>FIRST MIDDLE LAST<br><b>Henry Young</b>  |   |   | 15. MOTHER'S MAIDEN NAME<br>FIRST MIDDLE<br><b>Mary Roth</b>                                    |  |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(YES, NO OR UNKNOWN)<br><b>Yes WW I</b>   |   | 16b. SOCIAL SECURITY NO.<br><b>579-60-1466</b>  |   | 17. INFORMANT<br>ADDRESS<br><b>Mary C. Young-wife - (same as 13e)</b>                                  |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).<br>PART 1. DEATH WAS CAUSED BY:<br><b>4049</b> IMMEDIATE CAUSE (a) <b>Myocardial infarction</b><br>DUE TO, OR AS A CONSEQUENCE OF (b) <b>Coronary artery disease</b><br>DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertension</b><br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. |   |   |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b> |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)   |   |   |   |  |   |
| 19a. DATE OF OPERATION  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20a. AUTOPSY?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |   |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH<br>(IF EITHER NOTIFY MEDICAL EXAMINER)   |   | 21b. TIME OF INJURY<br>HOUR A.M. MONTH DAY YEAR<br><b>19</b>  |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)                         |   |
| 21d. INJURY OCCURRED<br>WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |   | 21e. PLACE OF INJURY<br>(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)  |   | 21f. LOCATION<br>STREET CITY OR TOWN COUNTY STATE<br><b>18111 Prince Philip Drive Olney, Md. 20832</b> |   |
| 22a. I certify that (1) this hospital attended the deceased from <b>4/24/83</b> to <b>4/25/83</b> , that (2) I saw the deceased alive on <b>4/24/83</b> , and that in my (my) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not see the body after death.  |   |   |   |  |   |
| 22b. SIGNATURE<br><b>Charles H. Ligon, M.D.</b>   |   | DEGREE<br><b>M.D.</b>   |   | 22c. DATE SIGNED<br><b>4-25-1983</b>   |   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br><b>Charles H. Ligon, M.D.</b>  |   | 22e. ADDRESS<br><b>18111 Prince Philip Drive Olney, Md. 20832</b>   |   |  |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br><b>Burial</b>  |   | 23b. DATE<br><b>4-28-1983</b>   |   | 23c. NAME OF CEMETERY OR CREMATORY<br><b>Arlington National</b>  |   |
| 23d. LOCATION<br>CITY OR TOWN COUNTY STATE<br><b>Arlington Virginia</b>   |   | 24. FUNERAL DIRECTOR<br><b>Hines/Rinaldi Funeral Home</b><br>ADDRESS<br><b>11800 N.H. Ave., Silver Spring, Md.</b>  |   |  |   |
| 25a. DATE REC'D. BY REGISTRAR<br><b>APR 26 1983</b>   |   | 25b. REGISTRAR'S SIGNATURE<br><b>John J. Canish</b>   |   |  |   |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

| STATE OF MARYLAND<br>DEPARTMENT OF HEALTH AND MENTAL HYGIENE<br>CERTIFICATE OF DEATH   |  |   |   |   |  |   |  |   |   |
|--|--|---|---|---|--|---|--|---|---|
| 1. FOR STATE REGISTRAR   |  |   |   |   |  |   |  |   |   |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST<br>Margaret S Youngblood  |  |   |   |   | 2a. DATE OF DEATH MONTH DAY YEAR<br>4-15-83                                    |   | 2b. HOUR<br>2:30 AM  |   |   |
| 3. SEX<br>Female   |  | 4. RACE<br>white  |   | 5. DATE OF BIRTH MONTH DAY YEAR<br>3-1-08   |  | 6. AGE (IN YEARS LAST BIRTHDAY)<br>75   |  | 7. IF UNDER 1 YEAR MONTHS DAYS<br>IF UNDER 24 HRS. HOURS MIN. |   |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)<br>Washington DC   |  | 7b. CITIZEN OF WHAT COUNTRY?<br>U.S.A   |   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 9. BALTIMORE CITY OR COUNTY OF DEATH<br>Montgomery county MD                      |  |   |   |
| 10. CITY OR TOWN OF DEATH<br>Bethesda, Md.   |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)<br>Suburban Hospital |   |   |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)<br>BUSINESS OWNER   |  | 12b. KIND OF BUSINESS OR INDUSTRY                             |   |
| 13a. STATE<br>MD   |  | 13b. COUNTY<br>MONTGOMERY   |   | 13c. CITY OR TOWN<br>CHEVY CHASE  |  | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  | 13e. STREET ADDRESS<br>3707 EAST WEST HIGHWAY                 |   |
| 14. FATHER'S NAME FIRST MIDDLE LAST<br>GUSTAV SAVER  |  |   |   | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST<br>ELLEN MOYNER  |  |   |  |   |   |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)<br>NO  |  | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)<br>577-03-4399   |   | 17. INFORMANT ADDRESS<br>T. ALLEN PHILLIPS, 13413 LOCKSLEY LN. S.S. MD  |  |   |  |   |   |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)<br>PART I. DEATH WAS CAUSED BY:<br>IMMEDIATE CAUSE (a) PNEUMONIA<br>4860<br>DUE TO, OR AS A CONSEQUENCE OF (b)<br>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.<br>DUE TO, OR AS A CONSEQUENCE OF (c) |  |   |   |   |  |   |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>8 days  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I:   |  |   |   |   |  |   |  |   |   |
| 19a. DATE OF OPERATION   |  |   | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED                    |   |  |   | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |   | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/><br>OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)   |  |   | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR<br>P.M. 19             |   | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) |   |  |   |   |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK   |  |   | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) |   | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE                                 |   |  |   |   |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/1, 1976, to 4/15, 1983, that (I) (we) lost<br>saw the deceased alive on 4/14, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated<br>above, (I) (we) (did) (did not) view the body after death.             |  |   |   |   |  |   |  |   |   |
| 22b. SIGNATURE<br>John E. Everett  |  |   |   |   | DEGREE<br>MD   |   | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> |   | 22c. DATE SIGNED<br>4/15/83   |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)<br>JOHN E. EVERETT   |  |   |   |   | 22e. ADDRESS<br>9400 Conn Av KENSINGTON, MD                                    |   |  |   |   |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)<br>ENTOMBMENT  |  |   | 23b. DATE<br>APRIL 18, 1983   |   | 23c. NAME OF CEMETERY OR CREMATORY<br>FT. LINCOLN MAUSOLEUM                    |   | 23d. LOCATION CITY OR TOWN COUNTY STATE<br>Brentwood MD  |   |   |
| 24. FUNERAL DIRECTOR NAME<br>John E. Everett   |  |   |   |   | 25a. DATE REC'D. BY REGISTRAR<br>APR 19 1983                                   |   |  |   |   |
| 25b. REGISTRAR'S SIGNATURE<br>John E. Everett  |  |   |   |   |  |   |  |   |   |

BP

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MADE IN THE U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 1B signs any injury, or other traumatic event, the medical examiner must be notified at once.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 3 1 1 1 4 3  
REG. NO.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR   |  | 2a. DATE OF DEATH MONTH DAY YEAR   |  | 2b. HOUR   |  |
| 1. DECEASED NAME (TYPE OR PRINT)   |  | 3a. RACE   |  | 3b. DATE OF BIRTH MONTH DAY YEAR   |  |
| Joseph (NMI) Zalesak   |  | Caucasian  |  | July 16, 1896  |  |
| 4. SEX   |  | 5. DATE OF BIRTH MONTH DAY YEAR  |  | 6. AGE (IN YEARS LAST BIRTHDAY)  |  |
| Male   |  | July 16, 1896  |  | 86 YRS.  |  |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)  |  | 7b. CITIZEN OF WHAT COUNTRY?   |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Czechoslovakia   |  | United States  |  | 9. BALTIMORE CITY OR COUNTY OF DEATH   |  |
| 10. CITY OR TOWN OF DEATH  |  | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) |  | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)  |  |
| Bethesda   |  | Suburban Hospital  |  | Mail Handler   |  |
| 13a. STATE   |  | 13b. COUNTY  |  | 13c. STREET ADDRESS  |  |
| Maryland   |  | Montgomery   |  | 9813 Montauk Avenue 20817  |  |
| 14. FATHER'S NAME FIRST MIDDLE LAST  |  | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)   |  |
| John Zalesak   |  | Elizabeth (Not Available)  |  | Yes WWI  |  |
| 17a. SOCIAL SECURITY NO.   |  | 17b. INFORMANT ADDRESS   |  | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  |  |
| 098-30-3998  |  | Mrs. Eva Zalesak, Wife, Same as item #13   |  | PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest  |  |
|  |  |  |  | 4100   |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction   |  |
|  |  |  |  | DUE TO, OR AS A CONSEQUENCE OF (c)   |  |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Chronic obstructive pulmonary Disease   |  |  |  |  |  |
| 19a. DATE OF OPERATION   |  | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  |  |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)   |  | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19   |  | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)   |  |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)                                     |  | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE   |  |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-7, 1983, to 4-28, 1983, that (I) (we) last saw the deceased alive on 4-27, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. |  |  |  |  |  |
| 22b. SIGNATURE   |  | DEGREE   |  | 22c. DATE SIGNED   |  |
| Kwang S. Kim   |  | M.D.   |  | 4-28-1983  |  |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT)  |  | 22e. ADDRESS   |  | 22f. DATE REC'D. BY REGISTRAR  |  |
| KWANG S. KIM   |  | 11500 Old Georgetown Rd., Rockville, MD. 20852   |  | MAY 2 1983   |  |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY)  |  | 23b. DATE  |  | 23c. NAME OF CEMETERY OR CREMATORY   |  |
| Burial   |  | April 30, 1983   |  | Gate of Heaven Cemetery Silver Spring, Maryland  |  |
| 24. FUNERAL DIRECTOR NAME  |  | 24b. ADDRESS   |  | 25a. DATE REC'D. BY REGISTRAR  |  |
| Robert A. Pumphrey   |  | Funeral Homes, P.A., Bethesda, Maryland  |  | MAY 2 1983   |  |





30% OCT 1961

